

EXHIBIT A

Princeton University
UnitedHealthcare
Princeton Health Plan (PHP)
Summary Plan Description

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January 2018

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Introduction

Princeton University offers the Princeton Health Plan (PHP) administered by UnitedHealthcare. Coverage under the PHP is available to you and your dependents as long as you and they meet the eligibility requirements defined in the *About Your Benefits* section of the Summary Plan Description Handbook.

If you are currently a non-citizen on a J-1 Visa, you are not eligible to participate in this plan.

The PHP is a point-of-service plan, which provides three levels of coverage: in-network preferred, in-network non-preferred, and out-of-network. With the PHP, you can choose any provider you wish, but you receive a higher level of benefits when you select a UnitedHealthcare Choice Plus in-network provider. In addition, when utilizing certain specialists, you will receive a higher level of benefit if you use a preferred in-network provider (see page 2 for additional information).

You do not have to obtain a referral for in-network or out-of-network care. There are some services that are not covered at the out-of-network level, such as Durable Medical Equipment. You should review the SPD for details or call UnitedHealthcare at (877) 609-2273 to confirm coverage prior to seeking services.

How the Plan Works

The PHP features three levels of coverage: in-network preferred, in-network non-preferred and out-of-network coverage. You may choose a UnitedHealthcare Choice Plus in-network provider and receive a higher level of benefits, or you can select an out-of-network provider and receive a reduced level of benefits. There are some services that are not covered out-of-network, such as Durable Medical Equipment. You should review the SPD for details or call UnitedHealthcare at (877) 609-2273 to confirm coverage prior to seeking services.

When utilizing specialists, first check to see if they are in a category that identifies in-network preferred specialist providers. On their website, www.myuhc.com, UnitedHealthcare's preferred providers are listed as Premium Tier 1. Below is a list of Premium Tier 1 categories and locations as of January 2018. For the most current list of categories and locations contact UnitedHealthcare.

UnitedHealthcare (Premium Tier 1) In-Network Preferred Specialists: Allergy; Cardiology; Ear, Nose and Throat (ENT); Endocrinology; Family Practice; Gastroenterology; General Surgery; Internal Medicine; Nephrology; Neurology; Neurosurgery-Spine; Obstetrics and Gynecology (OB/GYN); Ophthalmology; Orthopedics; Pediatrics; Pulmonology; Rheumatology; and Urology.

Locations with Limited or No Access to Preferred Specialists: AZ, CA, DE, GA, IN, KY, MA, MI, NC, NH, NV, OR, SC, TX, VT and WV. If you reside in one of these locations, and need to visit a UnitedHealthcare specialist in one of the Premium Tier 1 categories, contact the Human Resources Benefits Team at (609) 258-3302 for assistance.

In-Network Preferred Lab: LabCorp. is the preferred in-network lab for UnitedHealthcare. If you use any other in-network lab, you will be charged more and will also have to meet your annual deductible prior to services being covered. However, individuals who use the Quest lab on campus in McCosh Health Center will have their services covered at 100% (the UHC Explanation of Benefits will indicate that there is a charge, but you will not be billed by Quest).

In addition, prior authorization to determine medical necessity is required for certain in-network and out-of-network inpatient and outpatient services as well as for Hi-Tech radiology (CT, PET, MRI, MRA, Nuclear Medicine), and sleep studies. For a complete list, please see Page 26. If the service is deemed not medically necessary, the service will not be covered. For in-network services, it is the provider's responsibility to contact UnitedHealthcare for the prior authorization review. For out-of-network services, it is the member's responsibility to seek prior authorization. If certain out-of-network services are not submitted for prior authorization, the penalty will be no coverage. You will be responsible for 100% of the cost.

Plan Provision	In-Network Service	Out-of-Network Service
Referrals	You do not need a referral from a primary care physician to seek care from other physicians or specialists.	You do not need a referral from a primary care physician to seek care from other physicians or specialists.
Claim forms	No claim forms to file. Your provider will bill UnitedHealthcare.	You must file a claim form to be reimbursed for your expenses.
Treatment by Physician For Illness or Injury	You pay a \$20 copay for office visits to a primary care physician, a \$30 copay to a preferred specialist, or a \$60 copay to a non-preferred specialist.	You pay 40% coinsurance, after you have met your annual deductible, for office visits, preventive care, and most office based services.
Preventive and Contraceptive Services	You pay \$0 for preventive services and certain contraceptive services.	You pay 40% coinsurance, after you have met your annual deductible.
Other Services (for example: inpatient medical/surgical facility charges; inpatient mental health and substance use disorder care). Prior authorization required.	You pay 10% coinsurance after you have met your annual deductible.	You pay 40% coinsurance, after you have met your annual deductible. If you do not receive prior authorization, there will be no coverage; you will be responsible to pay 100%.
Annual Deductible The amount you pay each year before the plan begins covering particular medical expenses.	Individual: \$200 Family: \$400	Individual: \$750 Family: \$1,500
Coinsurance (out-of-pocket expense)	You pay 10% coinsurance after you have met your annual in-network deductible for most services.	You pay 40% coinsurance after you have met your annual out-of-network deductible for most services.
Coinsurance Limit (Out-of-pocket expense maximum) Total amount you pay out-of-pocket in a calendar year before plan pays 100% of your medical expenses.	Is determined based on your annual base salary as of January 1 (or your date of hire, if later). <i>See Annual Out-of-Pocket Maximum</i> on Page 6.	Is determined based on your annual base salary as of January 1 (or your date of hire, if later). <i>See Annual Out-of-Pocket Maximum</i> on Page 6.

Reasonable and Customary

When you use out-of-network providers, the maximum amount a plan will allow to be charged for a service is called “reasonable and customary” (R&C). This is determined by UnitedHealthcare using data provided by Fair Health, Inc. Costs above R&C are your responsibility. To search estimated R&C fees for services in your area, go to www.fairhealthconsumer.org or call UnitedHealthcare for assistance. For out-of-network services, the Plan pays 60% of the reasonable and customary (R&C) charge for most services. In addition to your 40% coinsurance, you may also be required to pay amounts above R&C. These amounts do not count toward your annual out-of-pocket maximum.

Note: Princeton University cannot guarantee that a specific provider, even though listed in the UnitedHealthcare directory will be available. Choice Plus network providers may end their contract with UnitedHealthcare, or decide not to accept new patients. If your health provider leaves the Choice Plus network, you may select another provider. If your network specialist leaves, you should work with your primary physician to choose another Choice Plus network specialist. If your provider does not participate and/or drops out of UnitedHealthcare’s Choice Plus network, this is not a qualifying event to change your medical plan coverage mid-year.

Copay

You pay a copay for office visits to an in-network provider (except for preventive care and certain contraceptive services), for emergency room care, and for treatment at an in-network urgent care center.

In-Network Office Visit Copay

When you visit an in-network provider because you are ill, you will pay a \$20 copay for an office visit to a primary care physician, a \$30 copay for an office visit to a preferred specialist, or a \$60 copay for a visit to a non-preferred specialist at the time of the office visit, regardless of whether or not you have met your annual deductible. Copays do not count toward your deductible, but they do count toward your annual out-of-pocket maximum. If your office visit is for a routine preventive examination, e.g., annual physical, well-child care, annual gynecological exam, or similar preventive care, no copay is required.

Note: If you are pregnant and utilizing an in-network provider, your prenatal office visits are covered at 100%. However, the initial office visit to diagnose the pregnancy is covered at a copay.

Emergency Room Copay

The emergency room copay is \$175, regardless of whether the hospital is part of the network or not. It is important to remember the following about the emergency room copay:

- The copay applies only if it is determined that the services were delivered for a true emergency as defined by the Plan, and there is not a less intensive or more appropriate place of service, or another diagnostic or treatment alternative that could have been used instead of emergency room services.
- If your emergency room visit is not considered a true emergency as defined by the Plan, the services will not be covered.
- The emergency room copay is waived if you are admitted to the hospital.

Urgent Care Center Copay

Urgent care is defined as care for a condition that needs immediate attention to minimize severity and prevent complications, but is *not* a medical emergency. If there is an urgent care center in your area, you have the option of visiting the center when an urgent care situation arises instead of going to your physician. You will pay a \$30 copay for services if the center is in-network. The visit is subject to the deductible and coinsurance if the center is out-of-network.

Annual Deductible

The annual deductible is the amount you must pay each year in covered expenses and coinsurance, before benefits are payable. Office visit copays do not apply to the annual deductible, but apply to the annual out-of-pocket maximum. There is an individual and family deductible for both in-network and out-of-network care. The in-network and out-of-network deductibles are tracked and accumulate separately. After an individual meets the annual deductible, benefits are payable for that person at 90% (in-network) and 60% (out-of-network) for most services. There are some exceptions. Please see the *Benefits Summary*, Page 7. The annual deductible for all covered individuals in a family will not exceed the family deductible. The individual and family deductible amounts are shown on Page 7. The annual deductible is applied toward your annual out-of-pocket maximum. Please see *Annual Out-of-Pocket Maximum*, Page 6.

The annual family deductible is cumulative among family members. This means that as an individual your services are only covered after you have met your individual deductible, or the family, as a unit, has met the family cumulative deductible.

The in-network deductible can only be met by accumulating the necessary total of in-network services, and the out-of-network deductible can only be met by accumulating the necessary total of out-of-network services. Therefore, if you have met your in-network annual deductible, this amount will not apply towards meeting your out-of-network deductible.

For example

Suppose you are hospitalized at a network facility because you require surgery and you have family coverage and your family deductible is \$400. Let's assume that your husband has already paid \$200 and your daughter has also paid \$200 toward their individual deductibles. Since the in-network family deductible has been met, you need only pay the balance of 10% (the plan pays 90%). When your annual family deductible

is satisfied under the in-network portion of the plan, any covered services that you receive from an in-network provider for the remainder of the year will be covered at the coinsurance percentage. If you decide to use an out-of-network provider, you will be required to meet the out-of-network deductible. The \$400 in-network deductible will not apply towards meeting the \$750 individual out-of-network deductible or the \$1,500 family out-of-network deductible.

Let's now assume that no member of your family has incurred expenses at the time of your hospitalization/surgery. You will pay the first \$200 (individual in-network deductible) of the hospital/surgical facility charges and the remainder of the facility charges will be covered at 90% coinsurance. You will never have to pay a deductible that is greater than the individual deductible for a single member of the family. As illustrated, if you decide to use an out-of-network provider, the in-network deductible you have paid will not apply towards the \$750 individual out-of-network deductible or the \$1,500 family out-of-network deductible.

Annual Out-of-Pocket Maximum

The maximum amount that you will pay out-of-pocket towards copays, deductibles, and/or coinsurance each calendar year is called the annual out-of-pocket maximum (OPM). The in-network and out-of-network OPM amounts are based on your annual base salary as of January 1, or your date of hire, if later.

- If your annual base salary is \$75,000 or under, the in-network individual OPM is \$1,550 and the in-network family OPM is \$3,100. The out-of-network individual OPM is \$4,500 and the out-of-network family OPM is \$9,000.
- If your annual base salary is \$75,001 to \$150,000, the in-network individual OPM is \$2,350 and the in-network family OPM is \$4,700. The out-of-network individual OPM is \$4,700 and the out-of-network family OPM is \$9,400.
- If your annual base salary is \$150,001 or above, the in-network individual OPM is \$3,100 and the in-network family OPM is \$6,200. The out-of-network individual OPM is \$6,200 and the out-of-network family OPM is \$12,400.

If you meet the annual OPM, covered expenses are paid at 100% of the reasonable and customary (R&C) limit. The annual OPM for in-network and out-of-network services are tracked and accumulate separately.

Keep in mind that the following payments do not count toward the annual OPM out-of-network services:

- Prior authorization non-notification penalty (see Page 29)
- Charges above the reasonable and customary (R&C) limits

You must continue to make these payments, when applicable, even if you have reached your annual OPM.

There is both an individual and family annual OPM for both in-network and out-of-network care. When the in-network individual annual OPM is reached in a calendar year, all in-network covered expenses are payable at 100% for that person for the rest of the calendar year. (Prior authorization non-notification penalties and R&C do not apply to in-network services). The annual OPM for all covered persons in a family will not exceed the family amount shown in the salary band chart below.

The same is true for the family annual OPM, and for both the individual and family annual OPM under the out-of-network portion of the Plan. However, the reimbursement is at 100% of the R&C limit, and you are responsible for charges above R&C. In addition, the prior authorization penalties apply to out-of-network services.

Expenses you incur that apply toward the annual OPM accumulate and are tracked separately for in-network and out-of-network services. In other words, in-network payments do not count toward your out-of-network limits and vice versa.

The R&C limit means the lesser of the amount charged, or the reasonable charge for a particular service in your area. To determine the R&C limit, UnitedHealthcare uses Fair Health, a national independent, not-for-profit corporation, to determine R&C charges for services. If you are charged an amount that exceeds the R&C limit, you must pay the difference. The reasonable and customary limit only applies to out-of-network expenses.

For Example

Your out-of-network doctor charges you \$120 for a covered service and the Plan determines that \$100 is the R&C limit for that service. Assuming you have already met your deductible, the Plan reimburses 60% of \$100 or \$60. You are responsible for the \$40 coinsurance (40% of \$100). You are also responsible for the \$20 difference between the R&C limit and the doctor's charge. You pay a total of \$60 for the service.

BENEFITS SUMMARY

This *Benefits Summary* summarizes the Covered Health Services and outlines provisions of the Plan, including benefit amounts, maximum amounts, copays and deductibles.

Payment Terms and Features

The table below provides an overview of Copays that apply when you receive certain Covered Health Services, and outlines the Plan's Annual Deductible and Out-of-Pocket Maximum.

Annual Out-of-Pocket Maximum by Salary Band

Salary Band Find the range which includes your January 1 (or salary at date of hire, if later) base salary to determine your in-network and/or out-of- network maximum annual out-of-pocket expense.		In-Network Annual Out-of- Pocket Maximum		Out-of-Network Annual Out-of-Pocket Maximum	
From	To	Individual	Family	Individual	Family
0	75,000	\$1,550	\$3,100	\$4,500	\$9,000
75,001	150,000	\$2,350	\$4,700	\$4,700	\$9,400
150,001	and over	\$3,100	\$6,200	\$6,200	\$12,400

	Tier 1 In-Network Preferred	Tier 2 In-Network Non- Preferred	Tier 3 Out-of-Network
Annual Deductible The amount that you pay each year before the plan begins covering particular medical expenses. Annual deductible cross applies.	Individual: \$200 Family: \$400		Individual: \$750 Family: \$1500
Coinsurance The percentage of medical expenses you pay out-of-pocket after you meet your deductible.	You pay 10% after deductible	You pay 20% after deductible	You pay 40% after deductible
Annual Out-of-Pocket Maximum (including deductible, copays and coinsurance)	Based on salary bands		Based on salary bands
Lifetime Maximum Medical/Surgical/Mental Health	Unlimited		Unlimited
HOSPITAL BENEFITS			
	Tier 1 In-Network Preferred	Tier 2 In-Network Non-Preferred	Tier 3 Out-of-Network
Inpatient Medical/Surgical Care from Specialist (including Maternity) Prior Authorization Required	You pay 10% after deductible	You pay 20% after deductible	You pay 40% after deductible. You pay 100% if you do not receive prior authorization.

Inpatient Care/Residential Treatment for Mental Health and Substance Use Disorder Prior Authorization Required	You pay 10% after deductible		You pay 40% after deductible. You pay 100% if you do not receive prior authorization.
Surgical (Inpatient/Outpatient) Anesthesia and use of an operating room or related facility in a hospital or authorized institution. Prior Authorization Required	You pay 10% after deductible		You pay 40% after deductible. You pay 100% if you do not receive prior authorization.
Emergency Room Services administered for conditions meeting the definition of an emergency. Non-emergency care not covered.	You pay \$175 copay; waived if admitted.		You pay \$175 copay; waived if admitted.
Prior Authorization Non-Notification Penalty The amount you must pay if you do not call Care Coordination (1-877-609-2273) to precertify services that require prior authorization. See page 29 for details.	No penalty for in network services		No Coverage. You pay the full cost for any procedure and/or admission if you do not receive prior authorization.
OUTPATIENT BENEFITS			
Preventive Care by Physician	You pay \$0		You pay 40% after deductible
Treatment by Primary Care Physician for illness or injury	You pay \$20 copay per visit		You pay 40% after deductible
Treatment by Standard Specialist (refer to page 2 for the list of tiered specialists)	You pay \$30 copay per visit		You pay 40% after deductible
Treatment by Tiered Specialist (refer to page 2 for the list of tiered specialists)	You pay \$30 copay per visit	You pay \$60 copay per visit	You pay 40% after deductible
Teladoc Network of board certified doctors that provide telephonic and video consults. Available 24/7/365 (855) 835-2362 www.teladoc.com/princeton	You pay \$0		Not applicable; all Teladoc doctors are in-network.

Physician Services Performed in a Hospital/Ambulatory Setting (refer to page 2 for the list of tiered specialists)	You pay 10% after deductible	You pay 20% after deductible	You pay 40% after deductible.
Annual Physical/Immunizations (Children: Seven exams in first 12 months of life, three exams the next 13 to 24 months, three exams the next 25 to 36 months, and one (1) exam every calendar year thereafter up to age 18). (Adults (18+): One exam every calendar year. Includes coverage for immunizations).	You pay \$0		You pay 40% after deductible
Prenatal/Maternity Care Prior Authorization Required depending upon length of hospital stay. See Pregnancy on page 18.	You pay a \$30 copay for the visit to diagnose the pregnancy. All other prenatal visits will be covered at 100%. Delivery: You pay 10% after deductible (pre & post-partum care included in surgical charge for delivery). You pay \$30 copay for post- partum office visits.	You pay a \$60 copay for the visit to diagnose the pregnancy. All other prenatal visits will be covered at 100%. Delivery: You pay 10% after deductible (pre & post- partum care included in surgical charge for delivery). You pay 20% for physician services performed during delivery. You pay \$60 copay for post-partum office visits	You pay 40% after deductible

Lactation Support and Breastfeeding Equipment (Call UnitedHealthcare at 877-609-2273 for more information)	You pay \$0		You pay 40% after deductible
Preventive Immunizations	You pay \$0		You pay 40% after deductible
Outpatient Hi-Tech Radiology (MRI, CT, PET, MRA and nuclear medicine) Prior authorization required.	You pay \$0 for services received at an independent facility; you pay 10% after deductible for services received in a hospital setting.		You pay 40% after deductible. You pay 100% if you do not receive prior authorization.
Outpatient Diagnostic Cardiology, Sleep Studies, and Cardiac Rhythm Implant Devices. Prior authorization required.	You pay \$0		You pay 40% after deductible. You pay 100% if you do not receive prior authorization
Outpatient Lab Services for Diagnosis or Treatment (refer to page 2 for the preferred lab information)	You pay \$0 for LabCorp	You pay 20% after deductible	You pay 50% after deductible
Outpatient X-Ray Services for Diagnosis or Treatment	You pay \$0		You pay 40% after deductible
Outpatient Mental Health and Substance Use Disorder See Additional Plan Benefits for description and Prior Authorization for Mental Health and Substance Use Disorder Services	You pay \$30 copay per visit		You pay 25% (no deductible required)
Applied Behavioral Analysis (ABA) Therapy Coverage to age 21 for children whose diagnosis is on the autism spectrum. Prior authorization required.	You pay \$30 copay per visit		You pay 25% (no deductible required). You pay 100% if you do not receive prior authorization.
Outpatient Short-Term Rehabilitation Therapy Short-term physical therapy. Maximum of 100 visits per calendar year (combined in-network/out-of-network), if services will result in significant improvement in member's condition within a 60 day	You pay 10% after deductible		You pay 50% after deductible

period.		
<p>Outpatient Short-Term Rehabilitation Therapy</p> <p>Short-term occupational or speech therapies, and pulmonary and cardiac rehabilitation. Maximum of 100 visits each type per calendar year (combined in-network/out-of-network), if services will result in significant improvement in member's condition within a 60 day period. For speech therapy both restorative and non-restorative services are covered.</p> <p>Cognitive rehabilitation therapy following a post-traumatic brain injury or cerebral vascular accident is covered only when Medically Necessary.</p>	You pay 10% after deductible	You pay 40% after deductible
<p>Outpatient Therapeutic Treatments</p> <p>Dialysis, intravenous chemotherapy or other intravenous infusion therapy and other treatments. Prior authorization required.</p>	You pay \$0 after deductible	You pay 40% after deductible. You pay 100% if you do not receive prior authorization.
OTHER BENEFITS		
<p>Acupuncture Services</p> <p>Limited to 20 visits per calendar year (combined in-network/out-of-network).</p>	You pay \$30 copay per office visit	You pay 40% after deductible
<p>Ambulance Services –</p> <p>Covers Medically Necessary Transport or Treatment</p>	You pay \$0	You pay \$0
<p>Chiropractic Services</p> <p>Limited to 20 visits per calendar year (combined in-network/out-of-network). Services related to physical therapy are covered under and accumulate towards the 100 visit outpatient rehabilitation therapy maximum - See the</p>	You pay \$30 copay per office visit	You pay 40% after deductible

Outpatient Short-Term Rehabilitation Therapy section for coverage information.		
Family Planning Services Infertility treatment - Diagnosis & treatment of underlying medical condition covered with no lifetime maximum. All other infertility treatment limited to \$20,000 lifetime maximum. Artificial insemination and ovulation induction limited to 6 attempts per lifetime. Advanced Reproductive Technology limited to 3 attempts for lifetime. Proof of inability to conceive is not required. Prior authorization is required.	You pay 10% after deductible if inpatient or outpatient service. If office visit charged, you pay \$30 copay	You pay 40% after deductible. You pay 100% if you do not receive prior authorization.
Preventive Care Preventive physicals, well-child care office visits (including scheduled immunizations), mammogram (one every year age 35 and over), Pap Smear, Well-woman care, and Prostate Specific Antigen (PSA) tests (available at age 40)	You pay \$0	You pay 40% after deductible
Nutritional Counseling Limited to twelve visits per calendar year. Requires prescription from physician.	You pay \$30 copay per office visit	You pay 40% after deductible
Home Health Care Includes visiting nursing care and private duty nursing care. Each visiting nurse care or private duty nursing care shift of four hours or less counts as one home health visit. Each such shift of over four hours and up to eight hours counts as two home health	You pay 10% after deductible	You pay 40% after deductible. You will pay 100% if you do not receive prior authorization.

care visits. Limited to 60 visits per calendar year (combined in-network/out-of-network). Prior authorization required.		
Hearing Exams Limited to one exam per calendar year. Requires prescription from physician.	You pay \$30 copay per office visit for a preferred provider or \$60 per office visit for a non-preferred provider.	You pay 40% after deductible
Hearing Aids Limited to maximum reimbursement of \$1500 every three years (combined in-network/out-of-network).	Plan pays 100% up to a maximum reimbursement of \$1500 every three years.	Plan pays 100% up to a maximum reimbursement of \$1500 every three years.
Skilled Nursing Facility/Inpatient Physical Rehabilitation Confinement and skilled nursing services in a hospital or specialized facility; Limited to 60 days per calendar year (combined in-network/out-of-network). Prior authorization required.	You pay 10% after deductible	You pay 40% after deductible. You will pay 100% if you do not receive prior authorization.
Hospice Care Room and board in a licensed facility or in your home; services of medical personnel; other services and supplies; Limited to inpatient maximum of 180 days (combined in-network/out-of-network). Prior authorization required.	You pay 10% after deductible	You pay 40% after deductible. You will pay 100% if you do not receive prior authorization.
Durable Medical Equipment Single purchase of any one type of equipment is covered including repair. Replacements allowed once every three years. This covers prosthetic devices, including foot orthotics. See Additional Benefits for	You pay 10% after deductible	Not Covered

description.		
Wigs – Limited to maximum reimbursement of \$2500 every three years for wigs or wig repair. Covered based on medical necessity e.g., chemotherapy, radiation (combined in-network/out-of-network)	You pay 10% after deductible	You pay 10% after in-network deductible.
Prescriptions – Administered by OptumRx. You will receive a separate ID card.	Retail copays: Generic \$5, Preferred Brand \$25, Non-Preferred Brand \$40 Mail Order copays: Generic \$10, Preferred Brand \$50, Non-Preferred Brand \$80 Member Pays the Difference Program for brand name medications that have a generic equivalent. See the Prescription Plan SPD for information.	
Routine Annual Eye Exams	Not covered	Not covered
Prescription Eyeglasses or Contact Lenses	Not covered	Not covered

Additional Plan Benefits

While the *Benefits Summary* provides an overview of your Covered Health Services under the PHP, this section includes additional details for your Covered Health Services regarding:

- Allergy Testing and Treatment
- Family Planning Benefits and Infertility
- Pregnancy Benefits
- Mental Health and Substance Use Disorder Benefits
- Dental – Oral Surgery
- Durable Medical Equipment
- Prosthetic Devices
- Congenital Heart Disease Services
- Kidney Resource Services (KRS)
- Organ/Tissue Transplants
- Prescription Drug Benefits
- Preventive Care
- Gender Confirming Coverage
- Travel

Allergy Testing and Treatment

Testing and evaluations to determine the existence of an allergy are covered under the PHP. When a physician determines that an allergy exists, routine allergy injections, including serums, are also covered.

	In-Network	Out-of-Network
Allergy Injections	<u>Allergy Testing office visit:</u> You pay a \$30 copay per visit for a preferred network specialist, or a \$60 copay per visit for a non-preferred specialist. <u>Allergy Serum alone:</u> You pay \$0 if no office visit charged <u>Allergy injection alone:</u> You pay \$0 if no office visit charged <u>Allergy serum and injection billed on same day:</u> You pay \$30 copay if office visit charged by a preferred specialist, or a \$60 copay if office visit is charged by a non-preferred specialist. You pay \$0 if no office visit charged	You pay 40% after deductible

Family Planning Benefits and Infertility Services

The PHP covers a range of family planning benefits including the following:

- Sterilization
- Health services and associated expenses for abortion
- Contraceptive supplies and services
- Fetal reduction surgery
- Health services associated with the use of non-surgical or drug-induced pregnancy termination

Prior Authorization is required.

The PHP covers the first two visits per calendar year for contraceptive counseling at 100% in-network, and at 60% after the deductible for out-of-network services. The plan covers the office visit for injectable contraceptives, as well as for the fitting or insertion/removal of contraceptive devices at 100% in-network, and 60% after the deductible for out-of-network services.

The PHP covers infertility services for covered employees and their covered spouse. Prior authorization is required prior to seeking treatment. Infertility services are not provided for covered children. Infertility services are covered if the following tests are met: (Proof of inability to conceive is not required.)

- There exists a condition that:
 - is not caused by voluntary sterilization or a hysterectomy.

or

For a female whose:

- FSH levels are less than or equal to 19 mIU on day three of the menstrual cycle.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

Note: Infertility services for fertility preservation treatments and procedures are covered for men and women in the case of chemotherapy, pelvic radiotherapy, or other gonadotoxic therapies, as well as in advance of hormone treatment or gender surgery for male to female as well as for female to male changes, when a medical treatment or procedure will compromise or end the patient's ability to reproduce. *(Contact UnitedHealthcare at 877-609-2273 for more information.)*

The following infertility services expenses will be covered:

- Ovulation induction with ovulatory stimulant drugs, subject to a maximum of six courses of treatment in a covered person's lifetime.
- Artificial insemination, subject to a maximum of six courses of treatment in a covered person's lifetime.
- Advanced Reproductive Technology (ART), subject to a maximum of three attempts in a covered person's lifetime.

These expenses will be covered on the same basis as for disease.

A course of treatment is one cycle of treatment that corresponds to one ovulation attempt.

Not more than \$20,000 will be paid for all infertility services expenses in a covered person's lifetime. In figuring the above ART Lifetime Maximum, UnitedHealthcare will take into consideration all of the following, whether past or present:

- Services received while covered, under a plan of benefits offered by UnitedHealthcare or one of its affiliated companies;
- Services received while covered under a plan of benefits, on an individual or group basis, whether insured or self-insured, offered by any other carrier; and
- Services received while no plan coverage was provided.

Not covered are charges for:

- Purchase of donor sperm or storage of sperm.
- Care of donor egg retrievals or transfers.
- Storage of cryopreserved embryos.

- Gestational carrier programs.
- Home ovulation prediction kits.

Advanced Reproductive Technology (ART) Expenses

The PHP will also cover expenses incurred by a covered female for advanced reproductive technology expenses up to a maximum of three attempts per lifetime, if all of the following tests are met (proof of inability to conceive is not required):

There exists a condition that:

- Is not caused by voluntary sterilization or a hysterectomy.

or

For a female whose:

- FSH levels are less than or equal to 19 mIU on day three of the menstrual cycle.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

Covered medical expenses will include the following services:

- In vitro fertilization (IVF),
- Zygote intra-fallopian transfer (ZIFT),
- Gamete intra-fallopian transfer (GIFT),
- Cryopreserved embryo transfers,
- Intracytoplasmic sperm injection (ICSI) or ovum microsurgery, and
- Care associated with a donor IVF program, including fertilization and culture.

These expenses will be covered on the same basis as for disease.

Pregnancy Benefits

An individual who becomes pregnant undergoes two types of care during the course of the pregnancy: prenatal office visits and hospitalization for the delivery of the child.

Office Visits

For in-network, you will pay a copay for the initial office visit to diagnose the pregnancy. The copay for a preferred specialist is \$30, and the copay for a non-preferred specialist is \$60. You will pay a \$0 copay for your in-network prenatal care office visits. You will pay 40% for out-of-network providers after you have met your out-of-network deductible.

Hospitalization

You will pay 10% coinsurance (in-network) and 40% coinsurance (out-of-network) after you satisfy the applicable deductible for facility services and supplies associated with the birth of your baby. The patient costs for tiered specialist fees will correspond to the tier of the specialist utilized. Therefore, you will pay 10% coinsurance for the preferred specialist fees, or 20% for non-preferred specialist fees. Coverage includes:

- At least 48 hours (for a normal vaginal delivery) or 96 hours (for a cesarean section) of inpatient care for the mother and newborn child (authorizations are required for longer lengths of stay). These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The hospital or other provider is not required to get authorization for the time periods stated above. Prior authorization is required for longer lengths of stay. If the mother agrees, the attending physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.
- Birth center and nurse-midwife services
- Routine well-baby care given for the duration of the baby's confinement

Pregnancy may be subject to the requirement to obtain notification. Please see the *Prior Authorization* section on Page 26.

For a hospital delivery, the hospital length of stay begins at the time of delivery or at the time of the last delivery in the case of multiple births. For a delivery outside the hospital, the hospital length of stay begins at the time the attending provider admits the mother and/or newborn as hospital patients in connection with childbirth.

Special prenatal programs are available. These programs are completely voluntary and there is no extra cost for your participation. To enroll, contact Care Coordination at the phone number listed on your member ID card during your first trimester, but no later than one month prior to the anticipated childbirth.

Mental Health and Substance Use Disorder Services

The PHP covers inpatient, residential treatment and outpatient care for mental health and substance use disorder treatment. Prior authorization is required for inpatient and residential treatment. The copay and coinsurance amounts apply as shown in the *Benefits Summary*. Mental health services include but are not limited to:

- Assessment
- Diagnosis
- Treatment planning
- Medication management
- Individual, family and group psychotherapy
- Psychological education
- Psychological testing

Mental health and substance use disorder services are administered by United Behavioral Health, which can be reached at 1-877-609-2273.

Telemental Health services are available, and are a convenient option that allows patients to video conference with a licensed health provider – including psychiatrists, psychologists and counselors – who can provide both therapy and medication management. Visits are covered the same cost as in-network in-person mental health visits. To schedule an appointment for this service go to www.myuhc.com and click on Mental Health and LiveandWorkWell.com.

Dental - Oral Surgery Services

Generally, dental services are not covered under the PHP. However, there are certain limited dental and oral surgical procedures that are covered in either an inpatient or outpatient setting:

- Diagnosis and treatment of oral tumors and cysts.
- Surgical removal of bony or partial bony impacted teeth.

Coverage is also provided for treatment of an injury to natural teeth or the jaw but only if:

- The injury occurs while you are covered under this plan.
- The injury was not caused, directly or indirectly, by biting or chewing, and initial treatment begins within three months of the injury.

Under the PHP, coverage also includes dental work, surgery and orthodontic treatment needed to remove, repair, replace, restore or reposition natural teeth damaged, lost, or removed or other body tissues of the mouth fractured or cut. Oral surgery may be subject to the Prior Authorization requirement. Please see *When to receive Prior Authorization*, Page 26.

Durable Medical Equipment

Durable Medical Equipment is only covered in-network when it meets each of the following criteria:

- Ordered or provided by a physician for outpatient use.
- Used for medical purposes.
- Not consumable or disposable.
- Not of use to a person in the absence of a disease or disability.

If more than one piece of Durable Medical Equipment can meet your functional needs, benefits are available only for the most cost-effective piece of equipment.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Dental braces are excluded from coverage.

The Plan provides benefits only for a single purchase (including repair/replacement) of a type of Durable Medical Equipment once every three calendar years. However, for children age 18 or younger, replacement is allowed once per year due to growth in stature.

UnitedHealthcare will decide if the equipment should be purchased or rented.

Durable Medical Equipment will not be covered out-of-network.

Prosthetic Devices

External prosthetic devices that replace a limb or an external body part are covered only in-network and limited to:

- Artificial arms, legs, feet and hands.
- Artificial eyes, ears and noses.
- Breast prosthesis as required by the Women's Health and Cancer Rights Act of 1998. Benefits include mastectomy bras and lymphedema stockings for the arm.
- Foot orthotics.

If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.

The prosthetic device must be ordered or provided by, or under the direction of a physician. Except for items required by the Women's Health and Cancer Rights Act of 1998, benefits for prosthetic devices are limited to a single purchase of each type of prosthetic device every three calendar years. However, for children age 18 or younger, replacement is allowed once per year due to growth in stature.

Prosthetic Devices will not be covered out-of-network.

Reconstructive Procedures

Services for reconstructive procedures, when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function.

Reconstructive procedures include surgery or other procedures which are associated with an injury, sickness or congenital anomaly. Prior authorization is required. The fact that physical appearance may change or improve as a result of a reconstructive procedure does not classify such surgery as a cosmetic procedure when a physical impairment exists, and the surgery restores or improves function.

Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical congenital anomaly without improving or restoring physiologic function are considered cosmetic procedures. The fact that a covered person may suffer psychological consequences or socially avoidant behavior as a result of an injury, sickness or congenital

anomaly does not classify surgery or other procedures done to relieve such consequences or behavior as a reconstructive procedure.

Please note that benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the Customer Service telephone number on your ID card for more information about benefits for mastectomy-related services.

Cancer Resource Services

UnitedHealthcare will arrange for access to certain of its network providers that participate in the Cancer Resource Services Program for the provision of oncology services. UnitedHealthcare may refer you to Cancer Resource Services, or you may self-refer to Cancer Resource Services by calling 866-936-6002. In order to receive the highest level of benefits, you must contact Cancer Resource Services prior to obtaining Covered Health Services. The oncology services include Covered Health Services and supplies rendered for the treatment of a condition that has a primary or suspected diagnosis relating to cancer.

In order to receive benefits under this program, Cancer Resource Services must provide the proper notification to the network provider performing the services. This is true even if you self-refer to a network provider participating in the program.

Benefits are provided for cancer clinical trials and related treatment and services. Such treatment and services must be recommended and provided by a physician in a cancer center. The cancer center must be a participating center in the Cancer Resource Services Program at the time the treatment or service is given. If you or a covered dependent are eligible, you will receive assistance with travel and lodging arrangements when necessary.

Congenital Heart Disease Services

Congenital Heart Disease (CHD) services may be received at a Congenital Heart Disease Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the CHD services when the service meets the definition of a Covered Health Service, and is not an experimental or investigational service or an unproven service. However, if the condition is life threatening (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may consider an otherwise experimental or investigational service to be a Covered Health Service. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, although unproven, the service has significant potential as an effective treatment for the condition.

Prior authorization is required for all CHD services, including outpatient diagnostic testing, in utero services and evaluation.

- Congenital heart disease surgical interventions.
- Interventional cardiac catheterizations.
- Fetal echocardiograms.
- Approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by UnitedHealthcare to be a proven procedure for the involved diagnoses.

Contact UnitedHealthcare at the telephone number on your ID card for information about CHD services.

Kidney Resource Services (KRS)

UnitedHealthcare will arrange for access to certain of its network providers participating in the Kidney Resource Services Program for End Stage Renal Disease (ESRD) and chronic kidney disease. You may be referred to KRS by UnitedHealthcare, or you may self-refer to KRS by calling 888-936-7246 and selecting the KRS prompt. In order to receive the highest level of benefits, you must contact KRS prior to obtaining Covered Health Services. The services include Covered Health Services and supplies rendered for the treatment and/or diagnosis relating to ESRD or chronic kidney disease.

In order to receive benefits under this program, KRS must provide the proper notification to the network provider performing the services. This is true even if you self-refer to a network provider participating in the program. Notification is required:

- Prior to vascular access placement for dialysis.
- Prior to any ESRD services.

When these services are not performed in a KRS facility, the appropriate in-network and out-of-network deductibles and coinsurance apply.

Organ/Tissue Transplants

Transplant benefits include the evaluation, hospital and physician fees, organ acquisition and procurement, transplant procedures, and follow up care for a period of up to one year after treatment. Prior authorization is required. UnitedHealthcare has designated a network of nationally recognized hospitals that perform major organ and tissue transplant procedures. The PHP covers transplants at these designated transplant facilities with all benefits payable at 90% of covered expenses after satisfying the annual deductible. When a transplant or any related care is performed at a facility other than a designated transplant facility, it is treated as any other surgical procedure and the appropriate in-network and out-of-network deductibles and coinsurance apply.

Qualified procedures include but are not limited to transplants of the heart, lung, liver, kidney, pancreas and small bowel, bone marrow transplants (either from you or from a compatible donor) and stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service. If you

or a covered dependent are eligible, you will receive assistance with planning, treatment and, when necessary, travel and lodging arrangements.

Benefits are also available for cornea transplants that are provided by a physician at a hospital. For cornea transplants, the appropriate in-network and out-of-network deductibles and coinsurance apply.

Under the Plan there are specific guidelines regarding benefits for transplant services. Contact UnitedHealthcare at the telephone number on your ID card for information about these guidelines.

Organ/tissue transplants are subject to the Prior Authorization requirement. Please see the *Prior Authorization* section on Page 26.

Travel and Lodging Expenses

UnitedHealthcare will assist the patient and family with travel and lodging arrangements for utilizing a Center of Excellence (COE) related to:

Congenital Heart Disease (CHD), Obesity surgery services, Transplantation services and Cancer-related treatments.

For travel and lodging services to be covered, the patient must be receiving services at a COE designated facility.

Expenses for travel and lodging for the transplant recipient and a companion are available under the Plan as follows:

- Transportation of the patient (provided he or she is not covered by Medicare) and one companion who is traveling to and/or from the site of the CHD service, the obesity services and Cancer-related treatments for the purposes of an evaluation, the procedure or necessary post-discharge follow-up.

Eligible Expenses for lodging and transportation for the patient (while not a Hospital inpatient) and one companion:

- Benefits are paid at a per diem rate of up to \$50 for one person or up to \$100 for two people. Princeton University will pay an amount above this rate, up to a per diem rate of \$250 for one person or up to \$500 for two people. UHC will let Princeton know when a claim for travel and/or lodging falls into this category, and the additional taxable reimbursement will be added to your pay.

If the patient is an enrolled dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed up to the \$250 for one person or up to \$500 for two people per diem rate, processed as described above.

Travel and lodging expenses are only available for Congenital Heart Disease (CHD), Obesity surgery services, Transplantation services and Cancer-related treatments at COE designated facilities. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

Airfare at coach rate.

Taxi or ground transportation.

Mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

A combined overall maximum Benefit of \$10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all cancer treatments, and transplant procedures, and CHD treatments and obesity surgery services during the entire period that person is covered under this Plan.

Prescription Drug Benefits

The Prescription Drug Program is administered by OptumRx and is independent of UnitedHealthcare. See the Prescription Plan SPD for information.

Preventive Care

In-Network

Preventive services are designed to help diagnose and prevent disease early. Preventive services, e.g., annual exams, colonoscopies, and mammograms, are covered at 100% in-network. A list of preventive services is available by contacting UnitedHealthcare.

When you visit a network provider for a routine examination (e.g., annual physical, well-child care, annual gynecological exam, etc.) there is no copay for all covered services, supplies, and tests associated with the visit. For example, if the in-network provider orders routine blood work as part of your physical, or if your child needs to receive a scheduled immunization, there will be no charge for these services.

The following are some of the covered services associated with preventive health care benefits for you and your dependents (if enrolled):

- Routine immunizations and routine physical exams (including any outpatient lab work/x-rays ordered at the time of the visit) once each calendar year
- Prostate specific antigen
- Breast examination and/or mammogram
- Pelvic examination
- Pap smear
- Child preventive care services given in connection with routine pediatric care, including PKU tests and immunizations

Out-of-Network

- When you visit an out-of-network provider for a routine examination, you will pay 40% coinsurance after you have met your annual deductible. The following exclusions apply:

- Any services for well-child care visits over the limit of 7 visits during the first year, or more than 3 exams in the second year, or more than 3 exams in the third year or more than 1 exam yearly thereafter are not covered.
- The annual visit is subject to the deductible and coinsurance payment.

Gender Confirming Coverage

Gender Confirming Coverage includes the following:

- Psychotherapy for individuals experiencing gender dysphoria
- Continuous Hormone Replacement Therapy with hormones of the desired gender (Hormone Replacement Therapy is covered under the Prescription Drug Program administered by OptumRx)
- Fertility preservation in advance of hormone treatment or gender confirming surgery
- Laser or electrolysis hair removal services for male to female participants experiencing gender dysphoria. Services must be provided by an in-network medical specialist, such as a Dermatologist or Plastic Surgeon. Coverage from a non-medical professional or out-of-network provider will not be covered.
- Speech/Voice therapy to help participants experiencing gender dysphoria communicate in a manner consistent with their gender identities. Services must be provided by a licensed speech therapist.

Gender Confirming Surgery

Gender Confirming Surgery requires prior authorization in order to ensure the readiness of the patient for such surgery as well as to confirm medical necessity exists for the transgender patient. These protocols follow guidelines established by WPATH for such surgery. Covered expenses include:

- Charges made by a physician for:
 - Performing the surgical procedure; and
 - Pre-operative and post-operative hospital and office visits.
- Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). Room and board charges in excess of the hospital's semi-private rate will not be covered unless a private room is ordered by your physician and precertification has been obtained.

Prior Authorization Requirements for all surgeries:

- 1) Age 18 or older;
- 2) Capacity to make fully informed decisions
- 3) Diagnosis of severe gender dysphoria
- 4) If medical/mental health conditions exist they must be well controlled

Additional prior authorization requirements and referrals may be needed for specific surgeries. Please contact UnitedHealthcare for additional information.

Exclusions:

- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics
- Storage of cryopreserved embryos
- Rhinoplasty and Blepharoplasty
- Cosmetic procedures including, skin resurfacing, chin implants, nose implants and lip reduction

Travel

UnitedHealthcare has a national network of physicians, hospitals, and healthcare providers throughout the United States. When traveling in the U.S., you access care as you normally would by either locating a participating provider to receive care under the in-network portion of the Plan, or by choosing an out-of-network provider to receive care on an out-of-network basis.

If you are traveling overseas on *University-sponsored* or *University-related business* and are enrolled in the PHP, you may be eligible to receive the in-network level of benefits coverage. Please contact the Human Resources Benefits Team at 609-258-3302 *before* you leave to determine if you qualify for this benefit.

If you are traveling overseas on personal business that is not University-sponsored or University-related (including vacation), your coverage is provided under the out-of-network portion of the Plan. If, however, you or a family member experiences an emergency situation while traveling on personal business, you should go directly to the nearest facility for treatment. In an emergency situation, benefits are payable as described under the in-network portion of the Plan.

Care Coordination

You and your physician make decisions about medical services and supplies that you should receive.

When you choose to receive services from non-network providers, we urge you to confirm with Care Coordination that the services you plan to receive are Covered Health Services, even if prior authorization is not required. That is because in some instances, certain procedures may not meet the definition of a Covered Health Service and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions such as:

- The cosmetic procedures exclusion. Examples of procedures that may or may not be considered cosmetic include: breast reduction and reconstruction (except for after

cancer surgery when it is always considered a Covered Health Service); vein stripping, ligation and sclerotherapy, and upper lid blepharoplasty.

- The Experimental, Investigational or Unproven Services exclusion (see Page 31).
- Any other limitation or exclusion of the Plan.

Prior Authorization

Prior authorization is required before you receive certain Covered Health Services. In general, network providers are responsible for notifying Care Coordination before they provide these services to you. When you choose to receive certain Covered Health Services from out-of-network providers, you are responsible for notifying Care Coordination to receive prior authorization before you receive these Covered Health Services.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products (which are typically provided under medical coverage, rather than prescription coverage), which United Healthcare determines to be:

- Medically Necessary;
- Included in the Sections: Benefits Summary and/or Additional Plan Benefits described as a Covered Health Service
- Provided to a Covered Person who meets the Plan's eligibility requirements, and
- Not otherwise excluded in this SPD.

Medically Necessary

Healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance abuse disorder, condition, disease or its symptoms, that are all of the following as determined by United Healthcare or its designee, within United Healthcare's sole discretion are considered medically necessary. The services must be:

- in accordance with *General Accepted Standards of Medical Practice*,
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*- approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Care Management

When you seek prior authorization as required, the Claims Administrator will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion.

UnitedHealthcare develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

The services for which you must prior authorization are:

- Clinical Trials
- Congenital Heart Disease (CHD) Surgeries
- Diabetes Services – If equipment is in excess of \$1,000
- Genetic Testing – BRCA (Genetic Testing is a Covered Health Service if the genetic testing is determined to be Medically Necessary following genetic counseling when ordered by a physician and authorized in advance by United Healthcare.)
- Home Health Care
- Hospice Care
- Hospital – Inpatient Stay
- Infertility Services

- Maternity Services – If inpatient stay exceeds 48 hours following a normal delivery or 96 hours following a cesarean section delivery.
- Neurobiological Disorders – Mental Health Services for Autism Spectrum Disorders – Inpatient and Outpatient
- Obesity Surgery
- Outpatient Hi-Tech Diagnostic/Therapeutic Services – CT Scans, Pet Scans, MRI and Nuclear Medicine
- Mental Health and Substance Use Disorder Services – Inpatient
- Reconstructive Procedures
- Skilled Nursing Facility/Inpatient Rehabilitation
- Sleep Studies – Outpatient Diagnostic Services
- Surgery – Inpatient or outpatient
- Therapeutic Treatments – Outpatient
- Transplantation Services

When to Receive Prior Authorization

For out-of-network services, in order to request Prior Authorization, you must notify Care Coordination of the scheduled service at least five working days prior to the date of service or admission. If a confinement is planned but no admission date is set, you must make two phone calls to Care Coordination: one when the confinement is planned and a second as soon as the admission date is set. For non-scheduled services, you must notify Care Coordination within one business day or as soon as is reasonably possible.

Emergency Care – When emergency care is required and results in admission to an out-of-network hospital or similar facility, your representative or physician must call Care Coordination within two working days of the date the stay begins. A working day is a day UnitedHealthcare is open for business. It does not include Saturday, Sunday, or a state or federal holiday. If it is not reasonably possible to call Care Coordination within two working days, notification must be made as soon as possible. When emergency care has ended, Care Coordination must be called before any additional services are received.

Pregnancy - Pregnancy is subject to the following notification time periods:

- Inpatient Hospitalization for Delivery of Child: For out-of-network benefits only, Care Coordination must be notified for prior authorization if the inpatient care for the mother or child is expected to continue beyond:
 - 48 hours following a normal vaginal delivery, or
 - 96 hours following a cesarean section.
 If the need for care is expected to continue, notification should take place prior to the end of the time periods above.
- Non-Emergency Inpatient Hospitalization Without Delivery of Child: For out-of-network benefits only, non-emergency hospitalization during pregnancy but before the admission for delivery requires notification as shown above under *Inpatient Admission to a Hospital*.

Home Health Care - For out-of-network benefits only, you must request Prior Authorization by notifying Care Coordination at least five working days before receiving services.

Hospice Care - For out-of-network benefits only, you must request Prior Authorization by notifying Care Coordination at least five working days before receiving services.

Reconstructive Procedures - For out-of-Network benefits only, you must request Prior Authorization by notifying Care Coordination at least five working days before receiving services to verify that they are Covered Health Services for which benefits are available.

Organ/Tissue Transplants - For in-network or out-of-network benefits, you must request Prior Authorization by notifying Care Coordination as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center).

To notify United Healthcare, call the Customer Service telephone number on your ID card.

Notification for Inpatient Mental Health and Substance Use Disorder Services

Inpatient Services - For a scheduled admission, you must request Prior Authorization by notifying the Mental Health/ Substance Use Disorder Administrator five working days before admission, or as soon as reasonably possible for non-scheduled admissions (including emergency admissions). If you fail to notify the Mental Health/Substance Use Disorder Administrator as required, you will be responsible for 100% of the charges for out-of-network services.

Prior Authorization Non-Notification Penalty (for Out-of-Network procedures)

There is a penalty of no coverage for out-of-network services for failing to call within the required timeframe. You will be responsible for 100% of the charges, and the penalty amount will not be applied toward your annual out-of-pocket maximum.

Appeals

If you or your physician does not agree with Care Coordination's determination on a pre-service request for benefits, you can appeal. Your request that Care Coordination reconsider the decision must be made in writing to: United Healthcare, P. O. Box 30432, Salt Lake City, UT 84130-0432 or by phone to: 1-877-609-2273 within 60 days of the decision.

If you, the physician, and Care Coordination still cannot find an acceptable solution, the decision can be re-appealed. Another health care professional will review the facts of the case and make a final decision.

What's Not Covered

How Headings in this Section are Used

To help you find specific exclusions more easily, this section uses headings. The headings combine services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

The Plan Does not Pay Benefits for Exclusions

The Plan will not pay benefits for any of the services, treatments, items or supplies described in this section, even if either of the following are true:

- It is recommended or prescribed by a physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in this SPD. If you have a question about whether a service or supply will be covered, contact UnitedHealthcare directly at 1-877-609-2273.

Alternative Medicine

- Acupressure, massage therapy, and Rolfing.
- Aroma therapy.
- Hypnotism.
- Herbal medicine, holistic or homeopathic care, including drugs.
- Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Comfort or Convenience

- Television, telephone or internet access.
- Beauty/barber or guest service.
- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers and humidifiers.
- Devices and computers to assist in communication and speech.

Cosmetic or Reconstructive Surgery/Physical Appearance

- Reconstructive surgery or treatment primarily to change appearance, unless noted otherwise. It does not matter whether or not it is for psychological or emotional reasons. For limited coverage of reconstructive surgery after a mastectomy, see Reconstructive Procedures on page 20.
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure.
- Cosmetic Procedures as defined in this SPD. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
- Wigs or toupees except for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury. Hair transplants, hair weaving or any drug if such drug is used in connection with baldness is not covered.
- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

Dental Services

- Care of or treatment to the teeth, gums or supporting structures such as, but not limited to preventive care, periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak.
- Services and supplies received for the evaluation and treatment of temporomandibular joint syndrome TMJ, whether the services are considered to be medical or dental in nature.
- Upper and lower jawbone surgery except when required for direct treatment of acute traumatic injury or cancer; orthognathic surgery, jaw alignment and treatment for the temporomandibular joint, except as a treatment for obstructive sleep apnea.
- Dental braces.
- Dental x-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia. The only exceptions to this are for any of the following: transplant preparation; initiation of immunosuppressives; or the direct treatment of acute traumatic injury, cancer or cleft palate.
- Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

Drug(s)

- Self-injectable medications.
- Non-injectable medications given in a physician's office except as required in an emergency.
- Over the counter drugs and treatments.

Experimental or Investigational Service(s)

- Experimental or Investigational Services and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
- Experimental or Investigational Services are Medical, surgical, diagnostic, psychiatric, mental health, substance abuse disorders or other health care services, technologies, supplies, treatments, procedures or devices that, at the time UnitedHealthcare makes a determination regarding coverage in a particular case, are determined to be:
 - Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use,
 - or
 - Subject to review and approval by any institutional review board for the proposed use, (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational)
 - or
 - The subject of an ongoing Clinical Trial that meets the definition of a Phase I, II or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.
- However, if you have a life-threatening illness or condition (one that is likely to cause death within one year of the request for treatment) UnitedHealthcare may consider an otherwise experimental or investigational service to be a Covered Health Service for that illness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that illness or condition.

Foot Care

- Routine foot care, except when needed for severe systemic disease or preventive foot care for covered persons with diabetes for which benefits are provided under the Plan. Routine foot care services that are not covered include cutting or removal of corns and calluses, nail trimming or cutting and debriding (removal of dead skin or underlying tissue).
- Hygienic and preventive maintenance foot care. Examples include cleaning and soaking the feet, applying skin creams in order to maintain skin tone and other services that are performed when there is not a localized illness, injury or symptom involving the foot.
- Treatment for flat feet.
- Treatment of subluxation of the foot.

Medical Supplies and Appliances

- Prescribed or non-prescribed medical supplies. Examples include:
Compression stockings, ace bandages, gauze and dressings.
Urinary catheters.

This exclusion does not apply to:

- Ostomy bags and related supplies
- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Additional Coverage Details* on page 34.
- Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Additional Coverage Details* on page 34.

Mental Health/Substance Use Disorder

- Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance use disorders that if, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's mental illness, substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.
- Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Mental Health Services as treatment for a primary diagnosis of insomnia, other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
- Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
- Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
- Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
- Outpatient cognitive rehabilitation therapy except as Medically Necessary following traumatic brain injury or cerebral vascular accident.

Nutrition and Fitness

- Megavitamin and nutrition-based therapy.
- Nutritional counseling for either individuals or groups except as specifically described in the *Benefit Summary*.
- Enteral feedings and other nutritional and electrolyte supplements that are taken orally, including infant formula and donor breast milk even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded.
- The following foods: foods to control weight treat obesity (including liquid diets), lower cholesterol or control diabetes; oral vitamins and minerals; meals you can order from a menu, for an additional charge, during an inpatient stay; and other dietary and electrolyte supplements.
- Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, and diversion or general motivation.
- Weight reduction or control programs unless there is a diagnosis of morbid obesity.
- Health education classes including, but not limited to asthma, smoking cessation, and weight control classes.

Organ Transplants

- Health services for organ, multiple organ and tissue transplants, except as described under *Additional Plan Benefits* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealth care's transplant guidelines.
- Any solid organ transplant that is performed as a treatment for cancer.
- Health services connected to the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the Plan).
- Health services for organ and tissue transplants that are not described in this section.
- Health services for transplants involving mechanical or animal organs.

Providers

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal residence.
- Services provided at a free-standing or hospital-based diagnostic facility without an order written by a physician or other provider. Services that are self-directed to a free-standing or hospital-based diagnostic facility. Services ordered by a physician or other provider who is an employee or representative of a free-standing or hospital-based diagnostic facility, when that physician or other provider:
 - Has not been actively involved in your medical care prior to ordering the service, or
 - Is not actively involved in your medical care after the service is received.
 This exclusion does not apply to mammography testing.

Services Provided under Another Plan

- Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.
- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- Health services while on active military duty.

Sleep

- Appliances for snoring.
- Medical and surgical treatment for snoring, except when associated with documented obstructive sleep apnea.

Travel

- Travel or transportation expenses, even though prescribed by a physician. Some travel expenses related to covered transplantation services may be reimbursed at the Plan's discretion.

Vision

- Eyeglasses, contact lenses, or eye refractions.
- Surgery that is intended to allow you to see better without glasses or other vision correction including radial keratotomy, laser, and other refractive eye surgery unless the covered person has a pre-surgical refractive error greater than eight diopters.

Other Services and Supplies

- Health services and supplies that do not meet the definition of a Covered Health Service as defined in this SPD. Covered Health Services are those health services including services, supplies or Prescription Drugs which the Claims Administrator determines to be all of the following:
 - Medically Necessary;
 - Described as a Covered Health Service in this Summary Plan Description (SPD); and
 - Not otherwise excluded in this Summary Plan Description under this section, *What's Not Covered*.
- Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
- Health Services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are

also excluded. This exclusion does not apply to services the Plan would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a “complication” is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a “complication” are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

- Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan.
- In the event that a non-network provider waives copayments and/or the annual deductible for a particular health service, no benefits are provided for the health service for which the copayments and/or annual deductible are waived.
- Charges in excess of eligible expenses or in excess of any specified limitation.
- Growth hormone therapy.
- Surrogate parenting.
- Treatment of benign gynecomastia (abnormal breast enlargement in males).
- Custodial care.
- Domiciliary care.
- Private duty nursing except when provided as a home health care benefit.
- Respite care.
- Rest cures.
- Psychosurgery.
- Medical and surgical treatment of excessive sweating (hyperhidrosis).
- Panniculectomy, abdominoplasty, thighplasty, brachioplasty, mastopexy, and breast reduction, except as described under gender confirming surgery. This exclusion does not apply to breast reconstruction following a mastectomy as described under *Reconstructive Procedures*.
- Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from injury, sickness, stroke, cancer, autism spectrum disorders or a congenital anomaly. Speech/voice therapy is also covered for participants experiencing gender dysphoria.
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing.
- Any charge for services, supplies or equipment advertised by the provider as free.
- Any charges prohibited by federal anti-kickback or self-referral statutes.

Claims Information

In-Network

When you receive services from a network provider, it is not necessary to file a claim. The provider is reimbursed directly from UnitedHealthcare. You will receive an

Explanation of Benefits (EOB) showing the details of the charges and benefits you received.

Out-of-Network

When you receive services from an out-of-network provider, you must pay for the visit and take the following steps to file a claim for reimbursement:

- Get a UnitedHealthcare claim form by visiting the website for Human Resources (www.princeton.edu/hr), or by visiting your Human Resources Office in person.
- Complete and sign the Employee portion of the form.
- Have the provider complete the Provider portion of the form or enclose a provider bill which includes the information listed under claim submission below.
- Send the form and a copy of the provider's bill to the address shown on the form.

When you submit a claim, you should make sure the bills and the form include the following information:

- Your name and UnitedHealthcare ID number or social security number.
- The patient's name.
- The diagnosis.
- The date the services or supplies were incurred.
- The specific services or supplies provided.

Claims must be submitted within a period of 12 months following the date the expense was incurred. No benefits are payable for claims submitted after the 12-month period unless it can be shown that it was not reasonably possible to submit them in a timely manner.

How and When Claims are Paid

UnitedHealthcare generally processes claims within 10 business days of the date of receipt. Reimbursement is made directly to you, except in the following cases:

- You have financial responsibility under a court order for a dependent's medical care, and then UnitedHealthcare will make payments directly to the provider of care.
- UnitedHealthcare pays benefits directly to network providers.
- You request in writing that payments be made directly to a provider. You do this by signing the appropriate authorization when completing the claim form.

UnitedHealthcare will send an Explanation of Benefits (EOB) to you along with your reimbursement. The EOB will explain how UnitedHealthcare considered each of the charges submitted for payment. If any claims are denied in whole or in part, you will receive an explanation.

Review Procedure for Denied Claims

When a claim for benefit payment is denied in whole or in part, you may appeal the denial. Please see the *About Your Benefits* section of the Summary Plan Description Handbook for an explanation of the claim review and appeal process.

Other Important Information

Coordination of Benefits

The PHP utilizes a coordination of benefits feature that applies when an individual is covered under more than one health care plan. This feature determines which plan has primary responsibility for paying benefits and which plan has secondary responsibility. The secondary plan will only make a payment after the primary plan, and only if it provides benefits in excess of the primary plan. For details about how the coordination of benefits works, please see the *About Your Benefits* section of this Summary Plan Description Handbook.

Your Rights Under ERISA

For information about your rights under the Employee Retirement Income Security Act (ERISA) and other important information, see the *About Your Benefits* section of this Summary Plan Description Handbook.

Reservation of Rights

The University reserves the rights to amend, suspend, or terminate its UnitedHealthcare Princeton Health Plan in whole or in part, at any time and for any reason. The University has full authority and discretion to construe, interpret and administer its plan. The plan is unfunded, and no employee or dependent shall have any right to, or interest in, any assets of the University which may be applied by the University to the payment of benefits. Neither the establishment of the plan, nor the provision of benefits to any person, shall be construed as giving an employee the right to be retained in the service of the University. The plan will be construed and enforced according to New Jersey State law.



About Your Benefits
Summary Plan Description
Health, Welfare, and Education Plans

Princeton University
 About Your Benefits
 Summary Plan Description
 Health, Welfare, and Education Plans

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Introduction

This document summarizes the following benefit plans offered by Princeton University:

- Health Care Plan (which provides medical, dental, Employee Assistance Program (EAP), health benefit expense account (HBEA), and dependent care expense account (DCEA) benefits)
- Total Disability Insurance Program
- Business Travel Accident Plan
- Group Life Insurance Program – Regular
- Group Life Insurance Program – Supplemental
- Vision Care Plan
- Group Long Term Care Plan
- Parking and Transit Reimbursement Account Programs
- Staff and Children's Educational Assistance Programs

This document describes general provisions that apply to all of the benefit plans offered by Princeton University. Details regarding each benefit plan are described online, which should be used in conjunction with this document for a full understanding of these benefit programs.

This document is not intended to provide medical, legal, financial, tax or investment advice. Complete details of each benefit plan are found in the official plan documents and contracts that legally govern all aspects of the plans. The plan documents are available for review in the Office of Human Resources. If there is any discrepancy between the plan documents and the summaries in this handbook, the plan documents will prevail. The University's benefit plans are intended to comply with all applicable federal and state laws. In the event of a conflict, the terms of the federal and state laws will govern. The benefits described in this document are based on federal and state laws as of January 1, 2007.

Changes in the University benefit plans may occur as a result of future legislation or at the discretion of the University. If your benefits do change, you will receive updated information. Please contact your Office of Human Resources if you have questions or need additional information about your benefits.

Although the University intends to continue each of the current benefit plans, it reserves the right to terminate or amend any plan, at any time, and for any reason.

Eligibility

This section describes employee and dependent eligibility for Princeton University's benefit plans.

Employee Eligibility

- Members of the faculty and staff whose work schedule is at least five months of the year at 50% duty time or greater are eligible to participate in the University's benefit plans.
- Casual, (biweekly and hourly paid) and short-term professional employees, temporary contract employees, and those who are full-time students are not eligible to participate in the University's benefit plans.
- Visiting faculty and staff may only be eligible for some of the following benefits.
 - Medical Benefits
 - Dental Benefits
 - Vision Benefits
 - Group Supplemental Retirement Annuity
 - Health and Dependent Care Expense Accounts
 - Faculty and Staff Assistance and Work/Life Programs
 - Princeton University Retirement Plan eligibility only via written approval by the Office of the Dean of the Faculty
- All J-1 visa holders are eligible for certain benefits based on job title or staff group. J-1 visa holders may be eligible for the same benefits as Visiting Faculty and staff listed above with the following exception:
 - Health Care – the only medical plan options are the J1 visa health plan option administered by Aetna or the Aetna HMO health plan.

Dependent Eligibility

If you are an eligible employee, you may enroll certain family members in the Medical, Dental, Vision Care Plans, and Long-Term Care. Your eligible dependents include your legal spouse, same-sex domestic partner or same-sex civil union partner, and eligible children to the December 31st in which they turn 26.

Coverage may be available to your eligible child regardless of student, residential, or marital status; however, if your child is married, the spouse and/or children of your eligible child are not eligible for coverage under our Plans. "Child" includes your biological, step, adopted, and foster children as well as the children of your same-sex domestic or same-sex civil union partner.

Eligible dependents also include:

- dependent, unmarried children of any age who are physically or mentally challenged and became disabled before the end of the calendar year in which they turn 26.
- Unmarried children of any age who are physically or mentally challenged who were covered dependents and became disabled before the end of the calendar year in which they turn 25 are also eligible dependents.

Same-Sex Domestic Partner

Your same-sex domestic partner (and his or her children, if any) qualifies as a dependent if:

- your partner is not related to you by blood,
- you and your partner have lived together in a committed personal relationship for at least six consecutive months, you agree to be jointly responsible for each other's common welfare, living expenses, and financial obligations, and you intend to live together indefinitely, and
- you must be able to present at least three forms of documentation showing your shared financial responsibilities.

There are two forms that must be completed in order for your same-sex domestic partner (and his or her children, if any) to be covered under the applicable benefit plans:

- Statement of Same Sex Domestic Partnership.
- Tax Certification of Dependency for Health Insurance Coverage. If your same-sex domestic partner and/or his/her children can be classified as tax dependents, you must complete this form in order to have benefits provided on a tax free basis. The form describes when your same sex domestic partner and/or his or her children are classified as tax dependents.

These forms are available via the Web at www.princeton.edu/hr/forms or you can contact your Office of Human Resources to request the appropriate forms.

Please Note: There may be important personal tax consequences that arise as a result of domestic partner coverage. For example, you may be subject to imputed income for tax purposes. For more information, contact your Office of Human Resources.

Enrollment Procedures

Enrollment in most benefit plans is not automatic. If you are eligible for coverage, you must enroll yourself and your dependents in order to receive coverage.

Initial Enrollment

When you are hired into a benefits-eligible position, you will receive enrollment information and an email notifying you to complete your online enrollment via eBenefits. You have 31 days from the date of hire to complete and submit your enrollment via our online system. For most benefits, with the exception of the Health Care Plan, if you do not enroll, you will not be covered, and will not be able to enroll until the next annual benefits open enrollment period. The table below describes the status of your enrollment and in relevant cases, the default coverage you receive if you do not enroll:

You must complete your online enrollment via eBenefits to enroll in the following plans	Within...	Or...
Medical Plan	31 days of your date of hire or appointment	You will be defaulted into the High Deductible Plan with employee only coverage (no prescription plan and a \$5,000 deductible). You will be unable to choose another health care plan until the next open enrollment period (with an effective date of January 1 of the following year).
Dental Care Plan	31 days of your date of hire or appointment	You are not eligible to participate in the calendar year of your hire.
Vision Care Plan	31 days of your date of hire or appointment	You are not eligible to participate in the calendar year of your hire.
Supplemental Life Insurance Plan	31 days of your date of hire or appointment	You are required to complete an Evidence of Insurability (EOI) form.
Health Benefit Expense Account Plan	31 days of your date of hire or appointment	You are not eligible to participate in the calendar year of your hire.

Dependent Care Expense Account Plan	31 days of your date of hire or appointment	You are not eligible to participate in the calendar year of your hire.
Parking and Transit Reimbursement Accounts	31 days of your date of hire or appointment	At any time using the appropriate enrollment/change form
Princeton University Retirement Plan	31 days of your date of hire or appointment	Your investment selection for University contributions will be defaulted to the Vanguard Target Retirement Funds.
Long Term Care	31 days of your date of hire or appointment	
Basic Life Insurance	Automatically enrolled and coverage effective on your first day of hire or appointment	Prudential will name your beneficiaries per their Preferential Beneficiary Arrangement, which provides that your life insurance will be paid to the first of the following: Your (a) surviving spouse; (b) surviving child(ren) in equal shares; (c) your surviving parents in equal shares; (d) surviving siblings in equal shares; (e) your estate.
Accidental Death and Dismemberment	Automatically enrolled and coverage effective on your first day of hire or appointment	
Business Travel Accident Insurance	Automatically enrolled and coverage effective on your first day of hire or appointment	
Short Term Disability	Automatically enrolled and coverage effective on your first day of hire or	

	appointment	
Long Term Disability	Automatically enrolled first of the month coincident with or next following one year of benefits eligible service.	

Special note regarding domestic partner coverage: The events qualifying you to make a mid-year election change described in this section also apply to events related to a domestic partner who is a tax dependent. If you make a mid-year change due to an event involving your domestic partner and your coverage for the domestic partner is on an after-tax basis these rules will not apply and you will be able to make a change at any time.

Open Enrollment

Current eligible employees can enroll in or change coverage elections during the annual benefits open enrollment period, which is held in the fall of each year. The benefit choices you make during each year's open enrollment period take effect on the following January 1 and will remain in effect until the following December 31.

In general, you may not make changes to your open enrollment elections until the following open enrollment period unless you experience a mid-year change as described below.

If you do not enroll during the annual benefit open enrollment period, your coverage under most plans defaults to your current election. However, you must actively make an election to enroll in the HBEA and DCEA for the next year.

Shortly after the open enrollment period ends, you will receive a confirmation statement showing the coverage you have elected (and/or any default elections) for the next year.

Mid-Year Changes

Ordinarily, you cannot change your benefit elections until the next annual benefit open enrollment period. However, you may be permitted to make a change during

the course of the year if you experience a mid-year election change event. Such events which are described in detail below include:

- a special enrollment event, such as losing coverage under another plan or gaining a new dependent;
- a qualified life status change event, such as an event that changes your marital or employment status;
- a significant change in coverage under spouse/or same-sex domestic partners other plan;
- entitlement to governmental benefits, such as Medicare;
- taking or returning from an approved leave;
- judgments, decrees, or court orders, such as QMCSOs; or
- other coverage changes that cause the need for a change to your coverage under the University's plans.

Special Enrollment Events

If you are rehired into a benefits-eligible position within six months of terminating from a benefits-eligible position, you will be reinstated into the benefits you were previously enrolled in. However, enrollment in the Health Benefits Expense Account and the Dependent Care Expense Account, if you are rehired in a new calendar year even if within the six months, requires a new election.

Loss of Other Health Plan Coverage

If you decline or waive coverage for yourself and your eligible dependents when you are originally eligible or during an open enrollment period because of other coverage and you subsequently lose that other coverage, then you may enroll yourself and your eligible dependents for coverage.

You must complete the enrollment process no later than 31 days after the date the previous coverage ends. Coverage for newly enrolled individuals will begin as of the first day of the month coincident or next following the last day of coverage under the previous plan.

You can make a change during the year by contacting your Office of Human Resources within 31 days of the event.

New Dependents

If you gain an eligible dependent as a result of marriage, you may enroll your spouse, and any other eligible dependent for benefits coverage. However, if you are enrolled you may also waive medical coverage. You must complete the enrollment process no

later than 31 days after the date of such event. Coverage will be effective the first of the month coincident with or next following the date of marriage.

In the case of the birth or adoption of a child, you have 90 days to notify your Office of Human Resources of the birth, adoption, or placement for adoption to add your dependents. Coverage will be added retroactive to the date of birth, adoption or placement for adoption.

Qualified Life Status Change Events

A qualified life status change event means:

- a change in your legal marital status, including marriage, divorce, death of your spouse or same-sex domestic partner, legal separation, or annulment;
- a change in the number of your tax dependents through birth, adoption, or death;
- termination or commencement of employment by you, your spouse, same-sex domestic partner, or dependent;
- a change in work schedule, such as reduction or increase in hours by you, your spouse, same-sex domestic partner or your dependent that would make you ineligible or eligible for benefits;
- your dependent's ability or inability to satisfy dependent eligibility requirements, for example, losing student status; or
- a change in residence or work site by you, your spouse, same-sex domestic partner, or dependents that causes you to lose access to providers in your medical plan's network.

For purposes of the foregoing, a qualified life status change will only occur with regard to a domestic partner and his or her dependents who if the domestic partner and his or her dependents are your tax dependents as discussed above in the Eligibility section.

Any change you make in your benefits must be consistent with the qualified life status change event. For example, if you marry during the year, you are permitted to change the level of health care plan coverage from employee only to employee and spouse, or family. You are not permitted to change plans, e.g., you may not move from the Preferred Provider Organization Plan to the Point-of-Service Plan.

You must notify your Office of Human Resources of a qualified life status change event within 31 days of the event to change your benefit coverage. In the case of the birth, adoption, or placement for adoption of a child, you have 90 days to notify your Office of Human Resources of the birth, adoption, or placement for adoption to change your coverage.

If you do not notify your Office of Human Resources within the time specified, you will not be able to add a dependent or make any other coverage changes until the next open enrollment period, with benefits coverage effective the following January 1.

Coverage and Cost Events

In some instances, you may be able to make changes to your benefit coverage for certain other reasons, as described below.

Cost Changes

If there is a significant increase or decrease in the cost of coverage, you may be permitted to:

- in the case of a significant decrease in cost, revoke your election and elect coverage under the less expensive option, or elect such less expensive option for the first time if you previously declined coverage, or
- in the case of a significant increase in cost, revoke your existing election and elect coverage under another option providing similar coverage (if no alternative similar coverage is available, you may revoke your election with respect to such coverage).

Coverage Changes

- **Curtailment or Loss of Coverage** . If your benefit coverage is significantly curtailed or ceases entirely, you may revoke your elections and elect coverage under another option providing similar coverage, if one is available. Coverage is significantly curtailed if there is an overall reduction in coverage generally. If the curtailment is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election for coverage.
- **Addition to or Improvement in Coverage**. If the University adds or significantly improves a coverage option during the year and you had elected an option providing similar coverage, you may revoke your existing election and instead elect the newly added or newly improved option.
- **Changes in Coverage under Another Employer Plan**. If the plan provided by the employer of your spouse, domestic partner who is a tax dependent, or dependent allows for a change in your family member's coverage (either during that employer's open enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change. For example, if your spouse elects family medical coverage during his or her employer's open enrollment period, you may drop your University health plan coverage.

Entitlement to Governmental Benefits

If you, your spouse, domestic partner who is a tax dependent, or dependent becomes entitled to, or loses entitlement to, Medicare, Medicaid or certain other governmental group medical programs, you may make a corresponding change to your coverage elections.

Approved Leave

If you return to service after taking an approved leave and are otherwise eligible to participate in the benefit programs, you will be reinstated on the same terms that applied prior to taking such approved leave. For more information, see Continuation of Coverage.

Judgment, Decree, or Order (including QMCSOs)

If a judgment, decree or order (including a qualified medical child support order (QMCSO)) requires the plan to provide coverage to your child or foster child, then the plan automatically may change your election under the plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of such judgment, decree or order, if you desire.

If the judgment, decree or order requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child if you provide proof to the plan administrator that such other person actually provides the coverage for the child.

Change in Family Status

It is important that you notify your Office of Human Resources within 31 days of any change in your family status, such as marriage, divorce, birth, or adoption of a child (have 90 days for birth or adoption), legal guardianship, marriage of a dependent child, and death of a spouse or child.

In general, the plan administrator will determine whether a requested change qualifies as a result of a mid-year election change event. Princeton University requires written documentation of any dependent's eligibility for plan benefits and/or the effective date of any mid-year election change event.

To change your election due to a mid-year election change event, you must notify your Office of Human Resources or Human Resources (main campus) at (609) 258-3302 and make the change within 31 days of the event—90 days for birth or adoption. The change will generally be effective the first of the month coincident or next following the date of the event that prompted the mid-year election change. In the event of a birth or adoption, the effective date will be retroactive to that date.

When Coverage Begins

The effective date of coverage depends on the provisions of the specific benefit plan. For some plans, the initial effective date of coverage is the date of your hire or appointment. For other plans, the initial effective date of coverage is the first day of the month coincident with or next following your hire or appointment date, or job and family status change. Please refer to the specific benefit plan summary for additional information about the effective date of coverage.

Paying for Coverage

The University provides Basic Life Insurance (including Accidental Death and Dismemberment Insurance and Business Travel and Accident Insurance), Short and Long Term Disability Insurance coverage, and Faculty and Staff Assistance and Work/Life Programs to you free of charge. In addition, the University makes a contribution to the Princeton University Retirement Plan on your behalf.

If you elect coverage in any one of the health care plans (with the exception of the High Deductible Plan), you and the University both contribute toward the cost of coverage. Your contribution will be deducted on a pretax basis from your paycheck. Some plans are employee pay all plans. These plans include: expense account(s), dental, vision, supplemental life, group long term care, the tax-deferred annuity, and parking and transit reimbursement accounts. The full amount for these plans is deducted from your paycheck.

Pretax Contributions

For most benefits-eligible faculty or staff members, when you complete your benefit election process, you authorize the University to deduct from your paycheck any contributions needed to pay your portion of the cost for your benefit elections. Under federal law, some of your contributions are taken from your earnings before taxes are deducted. As a result, you pay less in federal income and Social Security taxes.¹ Depending on your state of residence, pretax contributions may also reduce your state and local income taxes. The following premiums or contributions may be made on a pretax basis:

- Health care plan coverage,
- Dental care plan coverage,
- Vision care plan coverage,
- Expense account plan coverage,
- Parking and transit reimbursement accounts, and
- Tax-deferred annuity plan election.

Contributions to your supplemental life insurance coverage and group long term care are made on an after-tax basis which means the cost of these benefits is deducted after federal, state, and local income and Social Security taxes have been withheld.

Same-Sex Domestic Partners

The cost of coverage for a domestic partner is the same as the cost for a spouse. The cost of coverage for a domestic partner's child(ren) is the same as the cost for a dependent child. If your domestic partner and his or her child(ren) qualify as your

dependents under section 152 of the Tax Code, your contributions for domestic partner coverage will be taken before taxes are withheld and there will be no tax implications for you. To enroll a same-sex domestic partner and or his or her children as tax dependents, you must complete a Tax Certification of Dependency for Health Insurance Coverage. This form is available via the Web at www.princeton.edu/hr or from your Office of Human Resources.

However, if your same-sex domestic partner and his or her child(ren) do not qualify as dependents under section 152 of the Tax Code, you will pay your portion of the cost of the coverage provided to your domestic partner and his or her children on an after-tax basis and the value of the coverage for your domestic partner and/or his or her child(ren) paid for by Princeton University will be considered “imputed income.” The amount of imputed income will be shown on your pay statement and Form W-2 and you will pay taxes on the amount of imputed income. The value of the coverage paid for by Princeton University is calculated by determining the excess of the fair market value (FMV) of the coverage over the after-tax amount you paid for the coverage. Princeton University will not treat dependents of your same-sex domestic partner as your tax dependents under the Tax Code unless you notify the plan administrator that they are your tax dependents.

Since these tax requirements are complex, you should consult a tax professional for advice on your personal situation. To review the qualifications of a section 152 dependent, see IRS Publication 17, Your Federal Income Tax.

Coordination of Benefits

The coordination of benefits feature applies when you or a covered dependent are covered under a Princeton University benefit plan that provides health benefits and another plan that provides health benefits such as Medicare, a plan provided by your spouse/domestic partner's employer, or a no-fault insurance plan. This feature determines which plan or plans has primary responsibility for paying benefits and which plan has secondary responsibility. Keep in mind that whenever there is more than one plan, the total amount of benefits paid in a calendar year under all plans cannot exceed the amount that would have been paid if there had been no other coverage.

How Coordination Works

When you or a covered dependent are covered under more than one health care plan and your Princeton University health care plan is primary, the University plan pays a benefit first without regard to any coverage you may have under the other, secondary, plan. When your Princeton University benefit plan is secondary, the following calculations are made:

1. Determine the amount of benefits that would be payable under the University plan in the absence of the coordination of benefits provision.
2. Subtract the amount of benefits paid by other plans from the amount of benefits payable under the University plan before you make your claim to your Princeton University Health Care Plan for the same services.
3. You are paid the difference. The University's Plan will never pay you more than the benefit you would have received if you were only covered under the Princeton University benefit plan.

Which Plan Pays First

The plan administrator has the right to secure information for the determination of coordination of benefits. Once the information is secured, the following rules determine which plan is primary and which is secondary:

- As a Princeton University employee, coverage for you under the Princeton University benefit plan is primary for covered expenses.
- When your spouse or same-sex domestic partner is covered under the Princeton University benefit plan as a dependent and under another group plan as an employee, then the plan covering your spouse or same-sex domestic partner is primary and the University plan is secondary.
- When your dependent child is covered under both the University plan and your spouse's plan, the "Birthday Rule" is in effect. The Birthday Rule provides that the parent whose birthday falls earlier in the calendar year (year of birth is not a consideration) is the parent whose coverage is primary. For example, a mother

and father both cover a child under employer-sponsored plans. The mother's birthday is in May while the father's birthday is in October. Therefore, the mother's plan is primary and the father's plan is secondary. If both parents have the same birthday, the plan covering a parent for the longer period of time is primary.

- When a dependent child of divorced or separated parents is covered under more than one health care plan, benefits for the child are determined in the following order:
 - Primary, the plan of the parent with custody of the child.
 - Secondary, the plan of the spouse of the parent with custody of the child, if applicable,
 - Finally, the plan of the parent not having custody of the child.

If a court order has been made, the above rules are disregarded. A plan with no coordination of benefits provision is primary to one that has a coordination of benefits provision.

Medicare

If you have coverage through Medicare, the Princeton University benefit plan is primary if:

- eligibility for Medicare is due to your reaching age 65 and you are currently employed as a benefits eligible employee, at Princeton University, or
- eligibility for Medicare is based on End Stage Renal Disease (ESRD).

Medicare pays primary to the Princeton University benefit plan for you, if:

- eligibility for Medicare is due to disability and the employee is not actively at work or
- eligibility for Medicare is due to End Stage Renal Disease (ESRD), but only after the conditions and/or time periods specified in federal law cause Medicare to become primary.

Medicare Enrollment Requirements for Non-retired Employees

If you are age 65 and currently employed as a benefits-eligible employee, Medicare is secondary. The Princeton University benefit plan is primary. This means you submit your health care claims first to the Princeton University benefit plan, then to Medicare.

When the Princeton University benefit plan pays benefits first and you would like Medicare to supplement this benefit, you must enroll for Medicare Parts A and B.

When Medicare pays benefits first, benefits available under Medicare are deducted from the amounts payable under the Princeton University benefit plan, whether or not you have enrolled for Medicare. For those who are retired or on long term disability, enrollment in Medicare Parts A and B are required before you can receive a benefit.

Other Government Plans

If you are covered under a plan which is established under the laws of any government, the Princeton University benefit plan does not cover any services or supplies available to you through that plan, unless the government plan requires by law the Princeton University benefit plan to pay primary.

Recovery Provisions

Right of the Plan to Recover Improperly Paid Benefits

Princeton University has the right to recover an amount paid in error. For example, if you receive benefits for a service under the Princeton University benefit plan in error, and you also receive benefits from another plan for the same service, Princeton University and the plan vendor have the right to recover the amount paid to you by the other plan. You are not permitted to receive total benefits above the cost of the service provided. The same is true if payment is made in excess of what should have been paid under the Princeton University benefit plan.

Refund of Overpayments

If benefits are paid under the Princeton University benefit plan for expenses incurred, you or any other person or organization that was paid must make a refund to the Plan if:

- all or some of the expenses were not paid by you or did not legally have to be paid by you or
- all or some of the payment made under the Plan exceeded the benefits under the Plan.

The refund equals the amount paid in excess of the amount that should have been paid under the Plan.

If the refund is due from another person or organization, then you agree to assist Princeton University in obtaining the refund when requested.

If you, or any other person or organization that was paid, do not promptly refund the full amount, the amount owed will be deducted from any future claim reimbursements.

Subrogation

In the event that you suffer an injury or sickness as a result of an alleged negligent or wrongful act or omission of a third party, the Princeton University Health Care Plan has the right to pursue subrogation against any person or insurer.

The Princeton University Health Care Plan will be subrogated and succeed to your right of recovery against any person or insurer. The Princeton Plan may use this right to the extent of the benefits under the Plan. You must agree to help the Princeton University Health Care Plan use this right when requested.

When Coverage Ends

Employee Coverage

Employee coverage ends on the earliest of the following dates:

- the benefit plan is terminated;
- you are no longer eligible for benefits;
- you fail to make the required contributions;
- medical, dental, and vision benefits terminate the last day of the month in which employment terminates; life, supplemental life, health benefit care expense, account, dependent care expense account, or parking and transit reimbursement accounts terminate on the last day of employment;
- the last day of a period for which contributions for the cost of coverage have been made, if the contributions for the next period are not made when due;
- you cancel your coverage, as applicable; or
- you die.

Dependent Coverage

Dependent coverage ends on the earliest of the following dates:

- the last day of the month in which the employee's coverage ends,
- the last day of a period for which contributions for the cost of dependent coverage have been made if the contributions for the next period are not made when due, or
- the end of the calendar year in which the dependent stops being an eligible dependent.

Continuation of coverage for incapacitated children

A mentally or physically incapacitated child's coverage will not end due to age. It will continue as long as the child is considered to be a dependent and meet one of the following conditions:

- the child is incapacitated,
- the child is not capable of self-support, or
- the child depends mainly on the employee for support.

The employee must provide proof that the child meets one of these conditions when requested.

This proof is not required more often than once per year.

Continuation of Coverage

Princeton University provides continuation of coverage for health, dental, vision, the Health Benefit Expense Account (HBEA), and the parking and transit reimbursement accounts while on an approved leave of absence. Coverage continues for up to 12 weeks during a Family and Medical Leave Act (FMLA) leave of absence, as well as during a disability/medical leave. In certain situations, you may be responsible for paying premiums during your leave. If you are on a paid leave, payroll deductions continue. If you are on an unpaid leave for less than one month, upon your return premiums will be deducted from your pay retroactively. If you are on an unpaid leave for more than one month, you will receive billing coupons from the University. You are required to pay premiums during your leave. Contact your Office of Human Resources for additional information.

Continuing Coverage during FMLA

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take up to 12 weeks of leave each year for serious illness, the birth or adoption of a child, or to care for a spouse/domestic partner, child, or parent who has a serious health condition. State laws may allow for longer leaves.

If you take a paid leave of absence during FMLA, the cost of coverage will continue to be deducted from your pay on a pretax basis.

If you take an unpaid leave of absence that qualifies under FMLA, all benefits other than compensation-based benefits continue for you and your dependents.

Note that your monthly contributions during an unpaid leave are made on an after-tax basis.

If you lose any coverage during an FMLA leave because you did not make the required contributions, you must wait for the next Open Enrollment to re-enroll when you return from your leave.

If you do not return to work at the end of your FMLA leave, or your employment is terminated while you are on an FMLA leave, you will be entitled to purchase COBRA continuation coverage for your health, dental, vision, and the HBEA.

Special Rules Regarding Your Expense Accounts: If you're on an approved FMLA leave, you'll have the option of continuing your participation in the HBEA and DECA during the leave as long as you continue to contribute for the cost of the coverage during the leave.

When you take an unpaid FMLA leave, the entire amount you elected under your HBEA will be available to you during your leave period, less any prior reimbursement, as long as you continue to make your contributions during your leave of absence. If you stop making contributions, your coverage under the HBEA will terminate while you are on unpaid FMLA leave. In that case, you may not receive reimbursement for any healthcare expenses incurred after your coverage terminated.

If your coverage terminates during your leave, your HBEA elections may be reinstated if you return to work during the same year in which your leave began. You will have the choice of either resuming your contributions at the same level in effect before your FMLA leave, or you may elect to increase your contribution level to “make up” for the contributions you missed during your leave. If you simply resume your prior contribution level, then the amount available for reimbursement for the year will be reduced by the contributions you missed during the leave. If you elect to make up contributions, then the amount available for reimbursement will be the same amount you could receive immediately before the leave.

Regardless of whether you choose to resume your former contribution level, or make up for missed contributions, expenses incurred after your coverage terminated are not eligible for reimbursement.

Continuing Coverage during Military Leave

If you take a military leave, whether for active duty or for training, you are entitled to continue your health, dental, vision, and HBEA for up to 24 months. Your total leave, when added to any prior periods of military leave from Princeton University, cannot exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, your deductions will be taken retroactively. If the entire length of the leave is 31 days or longer, you will be required to pay up to 102% of the full amount necessary to cover an employee who is not on military leave. You will receive billing coupons from the Office of Finance and Treasury to pay for these benefit premiums. Unlike payroll deductions, amount paid by using the billing coupons will be paid on an after-tax basis.

If you take a military leave and your coverage under a benefit plan is terminated, you will need to re-enroll in benefits within 31 days of your return to active status. If you are on military leave and you do not return to work at the end of your leave, you may be entitled to purchase COBRA continuation coverage for the remaining months, up to a total of 18 months (see below).

Continuing Coverage during a Non-FMLA or Personal Leave

If you are on an unpaid leave of absence (LOA) that does not qualify for FMLA, health, dental, and vision coverage for you and your dependents and your

participation in the HBEA may continue for up to twelve months and you are responsible for payment of elected benefits during the leave.

Continuing Coverage after Your Employment Ends

The section contains important information about your right to a temporary extension of coverage under the Princeton University-sponsored group health plan. The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that Princeton University provide you and/or your covered dependents who are qualified beneficiaries under COBRA with the opportunity to continue coverage under the plan for a temporary period in certain instances where your coverage under the plan would otherwise end.

This SPD provides your initial COBRA notice. This SPD explains COBRA continuation coverage, your right to obtain it, and what you need to do to protect the right to receive it.

As a qualified beneficiary, you can elect to continue the health, dental, vision, or HBEA coverage in effect on the date your coverage would otherwise end. Qualified beneficiaries include you, your spouse/domestic partner, and dependent children who were covered under the plan immediately before coverage ends due to a qualifying event. A qualified beneficiary also includes a child born or placed for adoption with you while you are enrolled in COBRA continuation coverage, provided you notify the COBRA Administrator within 30 days of the event.

The Plan Administrator is Princeton University. The COBRA Administrator is:

PayFlex Systems
P.O. Box 3039
Omaha, NE 68103-3039
(800) 284-4885

Who is Covered

You should receive a letter from PayFlex Systems shortly after you become a benefits-eligible employee. If you are an employee who is covered by a Princeton University-sponsored health, dental, vision, or HBEA, you have a right to choose continuation coverage under the applicable benefit plan if you lose your coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

If you are the spouse of an employee, or a covered dependent child of an employee, and are covered by a Princeton University-sponsored health, dental, vision, or HBEA on the day before the qualifying event, you are a qualified beneficiary and

have the right to choose continuation coverage for yourself if you lose your coverage due to the reasons noted in the When Coverage Ends Section.

Special Rules for Domestic Partners: Although domestic partners and their eligible dependent children are generally not considered qualified beneficiaries for purposes of legal entitlement to COBRA continuation coverage, Princeton University does make COBRA coverage available to domestic partners and their eligible dependent children who meet the requirements for eligibility under the Plan. Accordingly, if you have enrolled your domestic partner and his or her eligible dependent children for coverage under the Plan and you terminate your domestic partnership, you must notify Princeton University within 31 days of the qualifying event. Your domestic partner and his or her eligible dependent children will be eligible to receive COBRA continuation coverage under the Plan as described in this section.

Your Duties

Under the law, the employee or a family member has the responsibility to inform Princeton University via your Office of Human Resources or main campus Human Resources at (609) 258-3302 of a divorce, termination of domestic partnership, or a child losing dependent status under a Princeton University-sponsored benefit plan that provides health, dental, vision, or HBEA benefits. You must notify your Office of Human Resources or main campus Human Resources at (609) 258-3302 within 60 days from the date of the divorce or a child losing dependent status or, if later, the date coverage would normally be lost because of the event. For the termination of a domestic partnership, this notice must be provided in writing within 60 days from the date of the termination of domestic partnership. If the employee or a family member fails to provide this notice to Princeton University during this notice period, any family member who loses coverage will not be offered the option to elect continuation coverage.

When Princeton University is notified that one of these events has happened, Princeton University in turn will notify you that you have the right to choose continuation coverage. If you or your family member fails to notify Princeton University and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, termination of domestic partnership, or a child losing dependent status, then the employee and family members will be required to reimburse the employer-sponsored group health plans for any claims mistakenly paid.

Princeton University's Duties

Qualified beneficiaries will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occurs that will result in a loss of coverage. The employee's:

- death,
- termination (for reasons other than gross misconduct),
- reduction in hours of employment, or
- Medicare entitlement.

Electing COBRA

To inquire about COBRA coverage, contact your Office of Human Resources or main campus Human Resources at (609) 258-3302. If you have questions regarding the election forms or process, contact PayFlex Systems at (800) 284-4885.

Under the law, you must elect continuation coverage within 60 days from the date you would lose coverage, or, 60 days after PayFlex Systems provides you notice of your right to elect continuation coverage if this is later. An employee or family member who does not choose coverage within the time period described above will lose the right to elect coverage.

If you choose continuation coverage, Princeton University is required to give you coverage that is identical to the coverage provided under the plan you are enrolled in at the time coverage stopped. Plan changes affect you the same as employees still in the plan.

If you elect continuation coverage and then have a child, either by birth, adoption, or placement for adoption, during the period of continuation coverage, the new child is eligible to be covered under COBRA as long as you notify PayFlex Systems within 90 days of the birth or adoption of the child in accordance with the terms our group health plan.

If you fail to notify PayFlex Systems as discussed above, you will not be offered the option to elect COBRA coverage for your child. Newly acquired dependents, other than children born to, adopted by, or placed for adoption with the employee, will not be considered qualified beneficiaries but may be added to your continuation coverage in accordance with the rules for changing coverage set forth above in Enrollment Procedures.

Separate Elections: Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, i.e., at Open Enrollment, each qualified beneficiary who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse/domestic partner or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. Similarly, a spouse/domestic partner or dependent child may elect different coverage than the employee elects.

Duration of COBRA

The law requires that you be afforded the opportunity to maintain continuation coverage for 18 months if you or your covered dependents lose group health coverage because of a termination of employment or reduction in your hours of employment.

Additional qualifying events, such as a death, divorce, termination of domestic partnership, or Medicare entitlement, that occur while the continuation coverage is in effect can result in an extension of an 18-month continuation period to 36 months. However, in no event will coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. You should notify PayFlex Systems in writing if a second qualifying event occurs during your continuation coverage period. This notice must be provided within 60 days from the date of the second qualifying event or the date coverage would normally be lost because of the second qualifying event if later. When PayFlex Systems is notified that one of these events has happened, the covered family member will automatically be entitled to the extended period of continuation coverage. If an employee or covered family member fails to provide the appropriate notice and supporting documentation PayFlex Systems during this 60-day notice period, the covered family member will not be entitled to extended continuation coverage.

Special Rules for Disability: The 18 months may be extended to 29 months if you or a covered family member is determined by the Social Security Administration to be disabled at the time of the qualifying event or at any time during the first 60 days of continuation coverage. This 11-month extension is available to all family members who are qualified beneficiaries due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified beneficiary must inform PayFlex Systems in writing within 60 days of the Social Security determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must inform PayFlex Systems in writing of this re-determination within 30 days of the date it is made at which time the 11-month extension will end.

Medicare: If you experience a termination of employment or reduction in hours following Medicare enrollment, your covered family members may elect COBRA coverage for up to 36 months from the date you become covered by Medicare or 18 months from your termination or reduction in hours, whichever is longer.

Health Benefit Expense Account (HBEA): Regardless of the type of qualifying event, you can elect to continue your HBEA until the end of the plan year.

Early Termination of COBRA

The law provides that your continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- Princeton University no longer provides coverage to any of its employees under that particular plan,
- the premium for continuation coverage is not paid on time (within the applicable grace period),
- the qualified beneficiary becomes covered after the date COBRA is elected under another health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation for any pre-existing condition of the individual,
- the qualified beneficiary becomes entitled to Medicare after the date COBRA is elected, or
- coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose preexisting condition limitations. If you become covered by another group health plan and that plan contains a preexisting condition limitation that affects you, your COBRA coverage cannot be terminated unless in the exceptional case where the other plan's pre-existing condition rule is excluded from the HIPAA rules.

COBRA and FMLA

A leave that qualifies under the Family and Medical Leave Act (FMLA) does not make you eligible for COBRA coverage. If you are covered under our health benefit plans, you will be eligible for COBRA if you decide not to return to active employment. Your continuation coverage will begin on the earliest of the following to occur:

- when you definitively inform Princeton University that you are not returning to work, or
- the end of the FMLA leave, assuming you do not return to work.

Cost of Coverage

You will be required to pay 102% of the cost of coverage which is the employee contribution and the employer contribution plus a 2% administrative fee. If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the cost of covering an employee and any eligible dependents, if applicable. In such a case this increase begins with the 19th month of COBRA coverage, provided that the disabled individual is one of the individuals who elected

the disability extension. The cost of group health coverage changes annually. If you elect COBRA coverage, you will be notified of these annual payment changes.

COBRA coverage is not effective until you elect it and make the required payment. You have an initial grace period, i.e., 45 days from the date of your initial election, to make your first premium payment. Thereafter, payments are due by the first day of each month to which the payments apply. Payments must be postmarked on or before the end of the 30-day grace period.

If you do not make timely payments, your COBRA coverage will be terminated as of the last day of the month for which you made timely payment.

Health Insurance Portability & Accountability (HIPAA)

Effective April 14, 2003

Disclosure Limitations of YOUR Plan Information

Princeton University sponsors various health care plans, including United Healthcare Choice Plus (PPO), United Healthcare Choice Plus POS, Aetna PPO, Aetna Choice POS II, Aetna HMO, Aetna High Deductible Plan, Aetna J-1 Visa Plan, Payflex Health Benefit Expense Account, and Medco Health Solutions Prescription Drug Plan.

The Princeton University health care plans listed above (hereinafter referred to collectively as “the PLAN”) are committed to both protecting the privacy of health information maintained by the PLAN and ensuring that outside vendors who perform services for the PLAN, such as the PLAN’s third-party administrators, also protect the privacy of such information. The PLAN is required by law to maintain the privacy of your “Protected Health Information” (as described below) and is committed to doing so. The PLAN also is required to provide you with this Notice of its legal duties and privacy practices with respect to your Protected Health Information and comply with the terms of this Notice.

Protected Health Information generally includes information that identifies you (such as your name or unique identifying numbers or geographic information), and that relates to payment for your health care, your health condition (such as an illness you may have), or health services you have received or may receive in the future (such as an operation).

The PLAN will generally obtain your written authorization before sharing your health information with others outside of the PLAN. However, the PLAN is permitted to use and disclose your health information without your written consent to:

- make or obtain payments (such as disclosing health information to a doctor to determine if a service is payable under the PLAN);
- conduct health care operations (such as using health information to do a cost analysis of the PLAN);
- recommend treatment alternatives (such as disclosing health information to a doctor who is determining how to treat a health condition);
- provide information about health-related benefits and services;
- communicate with an individual—that is, a friend or family member—involved in your care or the payment for your care (if agreed to by you, unless you are incapable of agreeing) or in an emergency situation;
- comply with a federal, state, or local legal requirement;

- comply with a court order or administrative proceeding or for law enforcement purposes;
- conduct health oversight activities or public health activities (such as to prevent a disease);
- counter serious threats to your health and safety or to provide reports to an appropriate government authority about possible victims of abuse, neglect, or domestic violence;
- provide information about decedents to funeral directors, coroners, or medical examiners or to facilitate organ, eye or tissue donation;
- provide information for specialized governmental functions (such as related to military missions);
- comply with workers compensation law;
- allow business associates of the PLAN (such as third-party administrators) to provide payment, treatment, or health care operation services.

Otherwise, the PLAN cannot disclose information about your or your dependents' health insurance, prescription drug coverage, or medical plan enrollment with anyone without a written authorization from you or your dependents. In addition, the PLAN cannot retaliate against you or your dependents for refusing to sign an authorization or revoking an authorization previously given. Further, your health information cannot be used for employment-related purposes.

This means that the PLAN cannot disclose your Protected Health Information with:

- officers and other employees of Princeton University, other than those who are involved in PLAN administration;
- spouses or other family members not directly involved in your care or the payment for your care, unless agreed to by you.

Your rights regarding your health information include the right to:

- request restrictions beyond those outlined above (although the PLAN is not required to agree to a requested restriction);
- receive confidential communications at only a specified phone number or mail or email address;
- inspect and copy your Protected Health Information;
- amend your Protected Health Information;
- an accounting of instances when your Protected Health Information has been disclosed;
- receive a paper copy of this Notice upon request.

Personal Representative

You have the right to name a personal representative who may act on your behalf with regard to your Protected Health Information. If you wish to take advantage of this right, please contact the Office of Human Resources at (609) 258-3302.

Policy Modifications

The PLAN may change its privacy practices from time to time. However, if a material change is made, the PLAN will revise this Notice and will notify you either by e-mail or mail of the changes.

Complaints

Federal law requires the PLAN to maintain the privacy of your PLAN records as set forth in this policy. If you believe your privacy rights have been violated, you can file a complaint with the Office of Human Resources at (609) 258-3302.

You may also file complaints with the Secretary of the Department of Health and Human Resources or with the third-party administrator for your particular plan. No one will retaliate or take action against you for filing a complaint.

Privacy Officer

To exercise your HIPAA rights under the PLAN, please contact the PLAN's designated Privacy Officer:

Megan Adams
701 Carnegie Center, Suite 439
Princeton, NJ 08544
E-mail: adamsm@Princeton.EDU
Campus Phone: (609) 258-2169
Campus Fax: (609) 258-3448

You can also contact the third-party administrator for your PLAN or the Office of Human Resources to discuss the privacy of your Protected Health Information.

CLAIMS REVIEW & APPEALS PROCESS:

Claims Review

The claims review begins by your filing a claim with the Plan Administrator. Any participant or beneficiary or his/her duly authorized representative (the "claimant") has a right to file a written claim for benefits. If, after you have read the information set forth in the plan benefit booklet and below, you have any questions regarding how to file an initial claim, please contact the appropriate Claims Administrator as described in the Plan Administration and Legal Information section of this document.

Each benefit plan has a specific amount of time, by law, to evaluate and process claims for benefits covered by ERISA. The length of time the benefit plan has to evaluate and process a claim begins on the date the claim is first filed and are described below.

Four categories of health benefit claims review are recognized:

Urgent Care Claims. Claims for which the application of non-urgent care timeframes could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function, or, in the judgment of a physician with knowledge of the patient's condition, would subject the patient to severe pain that cannot be adequately managed otherwise.

The Claims Administrator will notify you of the plan's determination, whether adverse or not, as soon as possible, taking into account medical requirements but, not later than 72 hours after receipt of the claim unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In the case of such a failure, the Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the plan, of the specific information necessary to complete the claim. Notification of the improper filing may be made orally, unless the claimant requests written notification. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Administrator will notify you of the plan's benefit determination as soon as possible, but no later than 48 hours after the earlier of the plan's receipt of the specified information or the end of the period afforded you to provide the specified additional information.

Pre-service Claims. Claims must be decided before a patient will be afforded access to healthcare, e.g., preauthorization requests.

The Plan Administrator will notify you of the Claims Administrator's determination, whether adverse or not, within a reasonable period of time, but not later than 15 days after receipt of the claim. This period may be extended by 15 days, provided the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Claims Administrator and notifies you, within the initial period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information.

If the claim is improperly filed, the Claims Administrator will notify you as soon as possible, but not later than five days after receipt of the claim by the plan, of the specific information necessary to complete the claim. Notification of the improper filing may be made orally unless you request written notification. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Post-service Claims. Claims involving the payment or reimbursement of costs for medical care that has already been provided.

For non-urgent post-service health claims, the plan has up to 30 days following receipt of the claim to evaluate and respond to claims for benefits covered by ERISA. This period may be extended by 15 days provided the Claims Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the plan and notifies you, within the initial period, of the circumstances requiring the extension and the date by which the plan expects to render a decision. In addition, the notice of extension must include the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

If you file a claim for a prescription you obtained at a retail or mail-order pharmacy, that claim will be treated as a post-service claim.

Concurrent Care Claims. Claims where the plan has previously approved a course of treatment over a period of time or for a specific number of treatments and the plan later reduces or terminates coverage for those treatments.

Concurrent care claims may fall under any of the other three categories, depending on when the appeal is made. However, the plan must give you sufficient advance notice to appeal the claim before a concurrent care decision takes effect.

If Your Healthcare Claim Is Denied

If your healthcare claim has been denied for any reason, you will receive a statement that will include:

- the specific reason for the claim denial;
- the specific provisions of the plan on which the determination is based;
- a description of any additional information needed to reconsider the claim and the reason this information is needed;
- a description of the plan's review procedures and the time limits applicable to such procedures;
- a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- if any internal rules, guidelines, protocols, or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocol, or other similar criteria, or a statement that a copy of such information will be made available free of charge upon request;
- for adverse determinations based on medical necessity, experimental treatment, or other similar exclusions or limits, either an explanation of the scientific or clinical

judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and

- for adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than three days after the oral notice.

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You or an appointed representative may appeal and request a claim review within 180 days after receiving the denial notice. The request must be made in writing and should be filed with the Claims Administrator. The claimant is also entitled to reasonable access to and copies of all information that is relevant to the claim. This includes all information (i) relied on in making the benefit determination, (ii) submitted to, considered, or generated by the program in considering the claim, and (iii) that demonstrates the program's processes for ensuring proper, consistent decisions.

The request for review should include:

- the patient's name and the identification number from the ID card,
- the date(s) of medical service(s),
- the provider's name,
- the reason the covered person believes the claim should be paid, and
- any documentation or other written information to support the covered person's request for claim payment.

The review will be conducted by the Claims Administrator or other appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination which is the subject of the review, nor the subordinate of such individual, including any physicians involved in making the decision on appeal if medical judgment is involved. Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate healthcare professional. No deference will be afforded to the initial adverse benefit determination. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable U.S. Department of Labor regulations. The review will take into account all comments, documents, records and other information submitted by the claimant relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

The Claims Administrator will notify you of the plan's determination on review within the following timeframes for:

- urgent health claims, as soon as possible considering the medical situation, but no later than 72 hours after receipt of the request for review;
- pre-service claims, within a reasonable period of time given the medical situation, but no later than 30 days after receipt of the request for review; and
- post-service claims, within a reasonable period of time, but not later than 60 days after receipt of the request for review.

The Claims Administrator will provide you with written notification of the plan's determination on review. In the case of an adverse benefit determination, such notice will indicate:

- the specific reason for the adverse determination on review;
- reference to the specific provisions of the plan on which the determination is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- a description of your right to bring a civil action under section 502(a) of ERISA following an adverse determination on review;
- if any internal rules, guidelines, protocols, or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- for adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- a description of your right to obtain additional information upon request about any voluntary appeals procedures under the plan.

The notice will also include the following information: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

If Your Long Term Disability Claim Is Denied

Coverage for Long Term Disability is provided through Prudential. If your initial claim for long term disability benefits is denied, in whole or in part, the Claims Administrator will provide you with a written explanation or electronic notification of the reasons for the denial within 45 days from the date the claim is received. The notice will include:

- the specific reasons for the denial;
- the specific program provisions on which the denial is based;
- a description of any additional information needed to reconsider the claim and the reason this information is needed;
- a description of the program's review procedures and the time limits applicable to such procedures;
- a statement of your right to bring a civil action under ERISA following a denial on review;
- any internal rules, guidelines, protocols, or similar criteria that were used as a basis for the denial, either the specific rule, guideline, protocols, or other similar criteria, or a statement that a copy of such information will be made available free of charge upon request; and
- for a denial based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

If Your Life Insurance, Business Travel Accident, or Long-Term Care Benefits Claim Is Denied

If the claimant receives a denial notice and disagrees, the claimant is entitled to apply for a full and fair review of the claim and the denial. The claimant or an appointed representative can appeal and request a claim review within 60 days after receiving the denial notice. The request must be made in writing and should be filed with the Claims Administrator.

The claimant is also entitled to reasonable access to and copies of all information that is relevant to the claim. This includes all information (i) relied on in making the benefit determination; (ii) submitted to, considered, or generated by the program in considering the claim; and (iii) that demonstrates the program's processes for ensuring proper, consistent decisions. The claimant should include in the claimant's appeal the reasons the claimant believes the claim was improperly denied and all additional information the claimant considers relevant in support of the claimant's claim.

The reviewer will reconsider the claimant's claim, and the claimant will receive a written notice of the decision within 60 days after the claimant files the appeal. If more time is needed, the reviewer may be permitted to have a 60-day extension, so long as the claimant is notified in advance of the need and reasons for the delay.

If the claimant's appeal is denied, the claimant will receive notice of a denial, which will include:

- the specific reasons for the denial;
- the specific program provisions on which the denial is based;
- a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits; and
- a statement of your right to bring a civil action under ERISA following a denial on review.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Secondary Benefit Claim Appeal Process

Any benefits eligible faculty and staff hired through the Office of the Dean of the Faculty or the Office of Human Resources, whose claim for benefits under a University benefit plan has been totally or partially denied by the insurance carrier/administrator, may request a review by the University of the claim(s) that were denied. To do so, the faculty or staff member must first follow the steps outlined in the insurance carrier/administrator's written explanation of how to appeal the denied claim(s). If the appeal is denied by the insurance carrier/administrator the faculty or staff member may follow the steps outlined below.

Application of General Benefit Claim Appeal Process

If the faculty or staff member believes that he or she has been adversely affected by a misinterpretation or misapplication of a University benefit plan, he or she may request a review of the denied claim(s) by the Office of Human Resources. All requests for a review of claims that have been denied by the insurance carrier/administrator should be submitted to the Director of Benefits, Office of Human Resources, 2 New South, within 30 business days from the final decision of the insurance carrier/administrator. The Director of Benefits will review the benefit plan and the specific claim and will advise the faculty or staff member of the decision, usually within 15 business days following receipt of the employee's request.

If the decision reached by the Director of Benefits regarding the claim under question is unsatisfactory to the employee, the employee may request that the

University's Benefits Committee review the matter in dispute. A written request for formal review by the Committee should be submitted to the University Benefits Committee, Office of Human Resources within 15 business days from receipt of findings from the Director of Benefits. After receipt of the employee's request for review, the Committee will consider the issues raised and will provide a written response to the employee, within 30 business days after completion of the review. The decision of the Benefits Committee is final.

You will have the opportunity to submit written comments, documents, records, and other information relating to the claim, and you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to the claim will be determined in accordance with the applicable DOL regulations.

The review will take into account all comments, documents, records, and other information you submitted relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

In certain cases, the program may obtain a limited time extension if notice of the extension is provided to you before the end of the initial decision making period.

Plan Administration and Legal Information

Plan Administrator

The Plan Administrator is responsible for the administration of the Princeton University benefit plans. The Princeton University Benefits Committee (the Committee) is the administrator for all of its plans. As such, the Committee has discretionary authority to interpret plan provisions, construe terms, determine eligibility for benefits and otherwise make all decisions and determinations regarding plan administration. By participating in any Princeton University benefit plan, you accept the Plan Administrator's authority. You may contact the Committee by sending a letter to the Princeton University Benefits Committee, Manager of Benefits, Office of Human Resources, 2 New South, Princeton University, Princeton, NJ 08544.

Claims Administrator

For some of the plans, the University, as plan administrator, has delegated authority to a third party to act as the Claims Administrator. The claims administrator for each Princeton University benefit is the company identified in the following chart unless a company is not identified. Princeton University delegates its authority to the Claims Administrator to apply the plan's provisions for benefit claims determinations.

The following chart includes the names, addresses, and phone numbers of the companies responsible for administering claims under the Plans. Use this chart as a reference when you need to contact a Claims Administrator regarding a claim. Detailed information about filing a claim under a particular plan may be found in the appropriate section of this book or the applicable benefit booklet.

Plan	Address	Phone
Preferred Provider Organization (PPO) UnitedHealthcare Options	Claims Department UnitedHealthcare Insurance Company PO Box 740800 Atlanta, GA 30374-0800	(877) 609-2273
Point-of-Service Plan (POS) UnitedHealthcare Select Plus	Claims Department UnitedHealthcare Insurance Company PO Box 740800 Atlanta, GA 30374-0800	(877) 609-2273
Point-of-Service Plan (POS) Aetna Choice POSII	Claims Department Aetna Life Insurance Company P.O. Box 981106 El Paso, TX 79998-1106	(800) 535-6689
Preferred Provider Organization (PPO) Aetna	Claims Department Aetna Life Insurance Company P.O. Box 981106 El Paso, TX 79998-1106	(800) 535-6689
HMO Aetna	Claims Department Aetna Life Insurance Company P.O. Box 981106 El Paso, TX 79998-1106	(888) 287-4296
High Deductible Health Plan Aetna	Claims Department Aetna Life Insurance Company P.O. Box 981106 El Paso, TX 79998-1106	(800) 535-6689
Prescription Drug Plan Medco Health For all medical plans (except the High Deductible Plan)	Medco Health P. O. Box 2187 Lee's Summit, MO 64063-2187	(800) 711-0917
DMO Dental Plan Aetna	Aetna Dental P. O. Box 14094 Lexington, KY 40512-4094	(877) 238-6200

Basic and High Dental Plan Metlife	Metlife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282	(800) 438-6388
Vision Care Plan Vision Service Plan	Vision Service Plan PO Box 2487 Columbus, OH 43216-2487	(800)-77-7195
Health BenefitExpense Account PayFlex Systems	PayFlex Systems P.O. Box 3039 Omaha, NE 68103-3039	(800) 284-4885
Dependent Care Expense Account PayFlex Systems	PayFlex Systems P.O. Box 3039 Omaha, NE 68103-3039	(800) 284-4885
Parking and Transit Reimbursement Accounts PayFlex Systems	PayFlex Systems P.O. Box 3039 Omaha, NE 68103-3039	(800) 284-4885
Long-Term Disability Plan The Prudential Insurance Company of America	Prudential Insurance Company of America 751 Broad Street Newark, NJ 07102-3777	(888) 257-0412
Basic and Supplemental Life Insurance Plan (and AD&D) The Prudential Life Insurance Company	Prudential Insurance Company of America 751 Broad Street Newark, NJ 07102-3777	(888) 257-0412
Faculty and Staff Assistance and Work/Life Program Carebridge Corporation	Carebridge Corporation The Greentree Plaza 40 Lloyd Avenue Malvern, PA 19355	(800) 437-0911
Business Travel Accident Plan Hartford Life Insurance	Hartford Life Insurance Company Health Claims Office-AD&D Claims Box 11910 Alexandria, VA 22312	(800) 368-3653 or (703) 824- 0600

Limitations on Rights

Participation in a plan does not give you the right to remain employed by the University. Also, you may not sell, transfer or assign either voluntarily or involuntarily the value of your benefit under any plan except that you may assign your basic life and supplemental life.

Plan Amendment or Termination

The University intends to continue each of the benefit plans. However, it reserves the right to terminate or amend any Plan at any time and for any reason.

Participant Rights/ERISA Requirements

As a participant in an employee welfare benefit plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all plan participants shall be entitled to certain rights. They include your right to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The administrator may assess a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.
- Obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65), and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to earn a right to a pension. This statement must be requested in writing and is not required to be given more than once every twelve months. The plan must provide the statement free of charge.
- Continue healthcare coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the Continuation of Coverage section of this summary plan description and the documents governing the plan for the rules governing your Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage rights.
- To receive a creditable coverage statement from this plan, which may reduce or eliminate exclusionary periods of coverage due to preexisting conditions under another group health plan. You will be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after you enroll in another group health plan.

Fiduciary Duties

In addition to creating rights for plan participants above, ERISA imposes duties upon the people responsible for the operation of employee benefit plans. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA. If your claim for a plan benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim.

Enforcement of Your Rights

If your claim for a health or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a court of competent jurisdiction. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You can also obtain certain procedures about your rights and

responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (800) 998-7542.

If you have any specific questions about any of the plans discussed in this summary plan description, contact the Human Resources Benefits at (609) 258-3302.

Employer Identification Number

The Internal Revenue Service has assigned the Employer Identification Number (EIN) 21-0634501 to Princeton University. If you need to correspond with a government agency about a benefit plan, use this number along with the plan name and the University's name.

Qualified Medical Child Support Order (QMCSO)

You may enroll your dependents in a health care plan if you are required by a qualified medical child support order (QMCSO), as legally defined to provide coverage for your dependents. If you are not enrolled in a plan at the time you receive such an order, you must enroll in a plan. Coverage is effective on the date specified in the QMCSO. You may obtain a copy of Princeton University's procedures governing QMCSO determinations, free of charge, by contacting Human Resources Benefits, Princeton University, 2 New South.

Fair Act

The FAIR Act of 1990 revised the rules governing personal injury protection provided through motor vehicle insurance policies issued or renewed in the State of New Jersey on or after January 1, 1991.

In New Jersey, motor vehicle insurance policies sold in the state are required by law to provide primary personal injury protection coverage ("PIP"), which pays for medical expenses resulting from a motor vehicle accident. In addition to this protection, most motorists carry additional health insurance through an employer. Under the FAIR Act, New Jersey state residents may choose whether primary medical coverage will be provided by their motor vehicle insurance policy's "PIP" coverage or by their employer's medical plan. However, the FAIR Act does not apply to self-insured health care plans. Because Princeton University offers its employees self-insured health care plans, your options under the FAIR Act depend upon which health care plan option you elect.

If you are covered under the one of the Princeton University health plans, you may not elect the plan as your primary insurance coverage in the event of a motor vehicle accident. You should have selected your motor vehicle insurance policy's "PIP" coverage as your primary coverage.

Women's Health and Cancer Act

Federal law requires group health care plans to cover certain reconstruction surgery following a mastectomy. Group health care plans must include under Covered Expenses, expenses associated with reconstruction of the breast on which the mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance; and the cost of prostheses and the costs for treatment of physical complications in all stages of the mastectomy, including lymphedemas (swelling associated with the removal of the lymph nodes.) These services are required to be provided in a manner determined in consultation with the attending physician and the patient. Coverage for these medical services is subject to the applicable deductible and coinsurance amounts.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours as applicable. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Contact Information

Several resources are available to you whenever you have questions about any of the information in this document:

Main Campus HR Benefits

Phone (609) 258-3302
E-mail hr@princeton.edu

Princeton Plasma Physics Lab (PPPL)

Phone: (609) 243-2101
E-mail: kmastrom@pppl.gov

Web site:

www.princeton.edu/hr

Carrier Contact Information:

www.princeton.edu/hr/benefits/newhire/resources/carriers

EXHIBIT B

HOW THE VALUE AND BUY-UP MEDICAL PLANS WORK**What this section includes:**

- Northwell Health, UHC In-Network, and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Copayment;
- Coinsurance; and
- Out-of-Pocket Maximum.

Northwell Health In-System Benefits

These benefits apply to Covered Health Services that are provided by an In-System Physician. Emergency Health Services are always paid as In-System Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by an In-Network facility and provided under the direction of either a Network or Non-Network Physician or other provider. In-Network Benefits include CIIPA Physician services provided in an In-System facility.

Whichever plan you choose, healthcare providers in the Northwell Health Clinical Integration Independent Practice Association (referred to as CIIPA or IPA) have agreed to see our employees at a set rate. Visit [Northwell.edu/insystem](https://www.northwell.edu/insystem) to choose your providers.

UHC In-Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the In-Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with United Healthcare (UHC) to provide those services.

You can choose to receive In-Network Benefits or Non-Network Benefits.

UHC In-Network Benefits apply to Covered Health Services that are provided by an In-Network Physician or other In-Network provider. Emergency Health Services are always paid as In-Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by an In-Network facility and provided under the direction of either an In-Network or Non-Network Physician or other provider. In-Network Benefits include Physician services provided in an In-Network facility by an In-Network or a Non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

Non-Network Benefits apply to Covered Health Services that are provided by a Non-Network Physician or other Non-Network provider, or Covered Health Services that are provided at a Non-Network facility.

Generally, when you receive Covered Health Services from an In-Network provider, you pay less than you would if you receive the same care from a Non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use an In-Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the Non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as In-Network Benefits

If specific Covered Health Services are not available from an In-Network provider, as determined by the Claims Administrator in its discretion, you may be eligible to receive In-Network Benefits from a Non-Network provider. In this situation your In-Network Physician will work with you and your In-Network Physician to coordinate care through a Non-Network provider.

Looking for an In-Network Provider?

In addition to other helpful information, www.myuhc.com, United Healthcare's consumer website, contains a directory of health care professionals and facilities in United Healthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Plan.

Directory of In-Network Providers

United Healthcare or its affiliates arrange for health care providers to participate in a Network. At your request, United Healthcare will send you a directory of In-Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call United Healthcare at 1-888-254-3698 or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of Northwell Health or United Healthcare.

The Claims Administrator's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Possible Limitations on Provider Use

If United Healthcare determines that you are using health care services in a harmful, inappropriate, or abusive manner, you may be required to select an In-Network Physician to coordinate all of your future Covered Health Services. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider and for a list of the participating primary care providers, contact United Healthcare at 1-888-254-3698 or log onto www.myuhc.com. If you don't make a selection within 31 days of the date you are notified, United Healthcare will select an In-Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the Non-Network level.

Eligible Expenses

Northwell Health has delegated to the Claims Administrator the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined (including, but not limited to, whether any payment under the Plan is payable and if so, in what amount) and otherwise covered under the Plan.

Eligible Expenses are the amount the Claims Administrator determines, in its discretion, that the Claims Administrator will pay for Benefits, plus the applicable cost-sharing (e.g., deductible, copays, coinsurance) which you must pay. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills but you are, of course, always responsible for your applicable cost-sharing. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you (including, but not limited to, your applicable cost-sharing plus the amount by which the bill exceeds Eligible Expenses) and the amount the Claims Administrator will pay for Eligible Expenses.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by the Claims Administrator, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law or those billed charges are unreasonable, as determined by the Claims Administrator in its discretion.

For Non-Network Benefits, Eligible Expenses are based on:

Negotiated rates agreed to by the non-Network provider and either the Claims Administrator or one of the Claims Administrator's vendors, affiliates or subcontractors, at the Claims Administrator's discretion.

If rates have not been negotiated, then one of the following amounts as determined by the Claims Administrator:

- Eligible Expenses are determined based on 140% of the published rates allowed by
- the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar
- service within the geographic market

When a rate is not published by *CMS* for the service, the Claims Administrator uses an available gap methodology to determine a rate for the service as follows:

- For services other than Pharmaceutical Products, the Claims Administrator uses a gap methodology established by *Optum Insight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, the Claims Administrator will use a comparable scale(s). United Healthcare and *Optum Insight* are related companies through common ownership by *UnitedHealth Group*. Refer to United Healthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
- For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *United Healthcare* based on an internally developed pharmaceutical pricing resource.

The Claims Administrator updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here and that difference (along with your applicable cost sharing) is your responsibility as it is not covered under the Plan.

- When Covered Health Services are received from a Network provider, Eligible Expenses are the Claims Administrator's contracted fee(s) with that provider.

Don't Forget Your ID Card

Remember to show your UnitedHealthcare ID card every time you receive health care services from a provider.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each calendar year for Covered Health Services before you are eligible to begin receiving Benefits under the Plan. There are separate Network and non-Network Annual Deductibles for this Plan; the amounts you pay toward your Annual Deductible accumulate over the course of the calendar year. Deductibles count toward the Out-of-Pocket Maximum.

Eligible Expenses charged by both In-Network and Non-Network providers apply towards both the Network individual and family Deductibles and the non-Network individual and family Deductibles.

Copayment

A Copayment (Copay) is the amount you pay each time you receive certain Covered Health Services. The Copay is a flat dollar amount and is paid at the time of service or when billed by the provider. Copays count toward the Out-of-Pocket-Maximum.

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible. Coinsurance counts toward the Out-of-Pocket-Maximum. **Coinsurance amounts are off of United Healthcare's reimbursement rates.*

Coinsurance – Example

Let's assume that you receive services for outpatient surgery from a Northwell Health In-System, and UHC In-Network provider under the Buy-Up Plan. First example, since the Northwell Health In-System Plan pays 100% you are responsible for paying 0%. This 0% is your Coinsurance. Second example, under the Buy-Up Plan the UHC In-Network Plan pays 90% after you meet the Annual Deductible, you are responsible for paying the other 10%. This 10% is your Coinsurance. ** Coinsurance amounts are off of United Healthcare's reimbursement rates.*

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each calendar year for Covered Health Services. There are separate Network and Non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a calendar year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the calendar year.

NORTHWELL HEALTH, HEALTH & WELFARE FLEX BENEFIT PROGRAM – SUMMARY PLAN DESCRIPTION

Eligible Expenses charged by both In-Network and Non-Network providers apply toward both the Network individual and family Out-of-Pocket Maximums and the Non-Network individual and family Out-of-Pocket Maximums.

United Healthcare is a private healthcare claims administrator. United Healthcare's goal is to give you the tools you need to make wise healthcare decisions. United Healthcare also helps your employer to administer claims. Although United Healthcare will assist you in many ways, it does not guarantee any Benefits. The Health System is solely responsible for funding the self-insured Benefits described in this PD/SPD from its general assets.

Please read this PD/SPD thoroughly to learn how the Plan works. If you have questions, contact your local Human Resources department or the Human Resource Service Center at 516-734-7000.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Northwell Health In-System Out-of-Pocket Maximum?	Applies to the UHC In-Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays	Yes	Yes	Yes
Payments toward the Annual Deductible	Not Applicable	Yes	Yes
Coinsurance Payments	Not Applicable	Yes	Yes
Charges for non-Covered Health Services	No	No	No
Charges that exceed Eligible Expenses	No	No	No

How the Medical Plan Works - Example

The following example illustrates how Annual Deductibles, Copays, Out-of-Pocket Maximums and Coinsurance work in practice.

Let's say Gary has individual coverage under the Plan. He has met his UHC In-Network Annual Deductible, but not his Non-Network Annual Deductible and needs to see a Physician. The flow chart below shows what happens when he visits a Network Physician versus a Non-Network Physician.

NORTHWELL HEALTH, HEALTH & WELFARE FLEX BENEFIT PROGRAM – SUMMARY PLAN DESCRIPTION

Northwell Health In-System Benefits	In-Network and Non-Network Benefits
<p>1. Gary goes to see a Physician in the Northwell Health Clinical Integration Independent Practice Association (CIIPA or IPA), and presents his ID card.</p>	<p>1. Gary goes to see a UHC In-Network or a UHC Non-Network Physician, and presents his ID card. His deductible is \$100.</p>
<p>2. He receives treatment from the Physician. The Plan's Eligible Expense for the In-Network office visit equals \$125</p>	<p>2. He receives treatment from the Physician. The Eligible Expense for his visit is \$175; however the Physician's fee is \$225.</p>
<p>3. On his way out, Gary pays the \$20 Copayment he is responsible for. Since In-Network Physician office visits are covered at 100% after the Copay, Gary has met his financial obligations for this office visit.</p>	<p>3. The Physician's office requests no payment, informing Gary that it will bill UnitedHealthcare directly.*</p>
<p>4. The Plan pays the physician \$105 (\$125 Eligible Expense minus \$20 Copay which employee pays</p>	<p>4. Gary is responsible for paying the deductible of \$100, the plan will pay \$75 and Gary will be responsible for \$50 if the provider bills him directly.</p>

*Although Non-Network providers have the right to request payment in full at the time of service, they bill United Healthcare directly in most cases.

CARE MANAGEMENT PROGRAM FOR EMPLOYEE HEALTH PLAN MEMBERS**What this section includes:**

- Clinical call center general information;
- Transitional Care Management program and how it works;
- Complex Care Management program and how it works;
- Diabetes wellness program and how it works

Clinical Call Center

The Clinical Call Center provides health assistance and support to Northwell Health employees and their dependents who are covered by Northwell Health's United Healthcare benefit plans and have urgent health questions or concerns, or experience a change in condition. All calls are answered by a team of experienced Registered Nurses who are certified in emergency care. The Center is accessible 24 hours a day, seven days a week, 365 days a year. Contacting the Clinical Call Center is completely confidential and totally free! Call 1-516-918-6005.

Transitional Care Management

Transitional Care Management is a thirty-day care navigation program aimed at improving safe discharge home and reducing avoidable readmissions for patients with an acute hospitalization or emergency department visit. All Northwell Health employees under the United Healthcare plans (referred to as Employee Health Plan or "EHP") and their dependents are eligible for Transitional Care Management services. All EHP patients with a medical or surgical admission (excludes normal newborn and normal maternity) to a Northwell Health facility are eligible for Transitional Care Management. At the time of admission, a real-time notification to the Health Solutions team will be sent through the Northwell Health Information Exchange (HIE). Health Solutions will attempt either an in-person or a telephonic outreach to engage the patient to inform them of the availability of the Transitional Care Management Program. Next, patients will be screened for clinical risk and risk for readmission upon engagement and throughout the care management engagement to determine appropriateness and frequency of services required post-discharge. High risk patients are eligible for a home visit and all patients will have telephonic contact with a nurse navigator or care manager to identify plan of care, coordinate all necessary services and educate the patient and/or caregiver as needed. All patients will have a medication reconciliation performed as needed and access to clinical triage available through the Health Solutions 24/7 Clinical Call Center. At the end of the thirty day (30) transition period, patients will be assessed for continued needs and extension of services or referral(s) to Health Solutions Complex Care Management Program (as defined below) or other offerings as determined to be clinically appropriate.

Complex Care Management

Complex Care Management is a longitudinal care coordination program that provides services to patients with complex medical needs and multiple co-morbid medical and social needs. Complex Care Management begins at the time of referral; whether the referral is directly from the EHP member or from the Transitional Care Management team. Marketing campaigns will be deployed to inform the Northwell Health employees of the availability of services. Patients in Complex Care Management are typically managed for a longer period of time and do not need to have the initial hospitalization to qualify. The Complex Care Management patient is one who may be having a difficult time with a specific diagnosis, (e.g. cancer), or a multitude of diagnoses (e.g. cardiac condition plus diabetes) and needs the assistance of a Registered Nurse and/or Resource Coordinator to provide ongoing education and monitoring of their health status. The Complex Care Management team manages all complex patients and can meet the care coordination needs of patients with cancer, cardiac, diabetes, hypertension, musculoskeletal, rheumatology needs and many other diagnoses. Health Risk Assessments (HRAs) are completed to identify patients' specific needs. Care Managers work with the patient to establish goals and create an individualized care plan to achieve those goals. We help the patient and care-giver learn to manage the illness(es) and will connect the patients to any additional resources they may need. We are your experts in community organizations and will help to find you those town, county, state, and federal entitlements for which you may be eligible. The Complex Care Team works as a member of the patient's care team; with the doctor and other providers, to ensure the patients receive the care they needs and that all members of the care team are on the same page as the patient.

Diabetes Wellness Program

The Diabetes Wellness Program provides resources to patients with diabetes and pre-diabetes to manage their condition and maintain a healthy lifestyle. The Program is accredited by the American Association of Diabetes Educators and supports patients, families, and health care providers by offering the latest treatments research and educational resources, and encourages community involvement. Patients will have access to a one-on-one, in person appointments and group education sessions. Follow up appointments will be scheduled according to individual goals and needs. Some patients may qualify for additional support from a registered nurse, who will assist patients with their medical needs. Patients will learn how to eat healthy, be active, reduce risks, cope with diabetes, problem-solve, monitor sugar levels, and take medicines. Educational programs are taught in locations throughout Nassau, Suffolk, Queens, and Manhattan. Patients in the Diabetes Wellness Program in need of additional services can be referred by either the Transitional Care Management or Complex Care Management program. Additionally, patients can call into the dedicated Employee Health Plan line and identify themselves as candidates for the Program. Patients enrolling in the Diabetes Wellness Program will first schedule an appointment with a member of the Diabetes Wellness Program team. Diabetes Educators will review the patients' medical records prior to the appointment and meet with the patient. During the initial appointment, the Diabetes Educator and patient will review labs and clinical needs, develop patient goals, assess

criteria for referral to other programs for additional support, and communicate appointment outcomes with the patients' PCP. Patients with qualifying medical needs will be referred to an RN for follow up, or will otherwise follow up with the Diabetes Educators according to the clinical assessment and patient goals. If you use the Northwell Diabetes program copays are \$0.

VALUE AND BUY-UP MEDICAL PLAN HIGHLIGHTS

The tables below provide an overview of Covered Health Services and outlines the Copays, Annual Deductible and Out-of-Pocket Maximum for the Value and Buy-Up medical options. Some Covered Health Services are described in more detail in *Additional Coverage Details under the Value and Buy-Up Plans*.

Out-of-Area Plans

Northwell assigns employees who live outside our primary service area who choose the Value or Buy-Up plans, the option of an Out-of-Area Plan (OOA) based on zip code. The two differences are:

1. If you are admitted to a non-Northwell hospital but UnitedHealthcare hospital your copay will be \$0.
2. A visit to your neighborhood physician's office will only cost you a copay (\$20/\$40) rather than the deductible and coinsurance.

NORTHWELL HEALTH, HEALTH & WELFARE FLEX BENEFIT PROGRAM — SUMMARY PLAN DESCRIPTION

VALUE PLAN	Northwell In-system	United Healthcare In-UHC network	Out-of-Network <i>reimbursement = 140% of Medicare. Participant pays the difference between United Healthcare payment and the provider charges.</i>
Deductible	\$0	\$1,000 Individual/ \$2,000 Family	\$3,000 Individual/ \$6,000 Family
Deductible Out-of-Area Plan (OOA)	\$0	\$750 Individual/ \$1,500 Family	\$2,500 Individual/ \$5,000 Family
Cardiac and Orthopedic Deductible (OOA Plan excluded)	\$0	\$5,750 Individual/ \$11,500 Family	\$8,500 Individual/ \$17,000 Family
Cardiac and Orthopedic Deductible OOA Plan	\$0	\$750 Individual/ \$1,500 Family	\$2,500 Individual/ \$5,000 Family
Coinsurance		30%	50%
Out-of-Pocket Max (includes deductibles, coinsurance/copays)	\$5,000 Individual/ \$10,000 Family	\$5,750 Individual/ \$11,500 Family	\$8,500 Individual/ \$17,000 Family
Hospital Copay	\$0	\$1,250 per admission Deductible/30% Coinsurance	\$1,500 per admission Deductible/50% Coinsurance
Hospital Copay OOA Plan	\$0	No copay Deductible/30% Coinsurance	\$1,250 per admission Deductible/50% Coinsurance
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Home/Office/Outpatient Care			
Preventive Care -Annual Exams -Immunizations	100% covered	Deductible/30% Coinsurance	Deductible/50% Coinsurance
Preventive Care OOA Plan -Annual Exams -Immunizations	100% covered	100% covered	Deductible/50% Coinsurance
Office Visits	\$20 Primary Care \$40 Specialist copay	Deductible/30% Coinsurance	Deductible/50% Coinsurance
Office Visits For OOA	\$20 Primary Care/ \$40 Specialist copay	\$20 Primary Care/ \$40 Specialist copay	Deductible/50% Coinsurance
Emergency Room Visit	\$200 copay (waived if admitted within 24 hrs)	\$200 copay (waived if admitted within 24 hrs)	\$200 copay (waived if admitted within 24 hrs)
Urgent Care	\$20 Copay at GoHealth, ProHEALTH, PM Pediatrics, CareMount Urgent Care	\$60 copay	Deductible/50% Coinsurance
Maternity Care	100% covered	Office Visit (first visit only): \$20 copay , Delivery: Deductible/Coinsurance and hospital copay (waived for OOA)	Deductible/50% Coinsurance and hospital copay

NORTHWELL HEALTH, HEALTH & WELFARE FLEX BENEFIT PROGRAM — SUMMARY PLAN DESCRIPTION

VALUE PLAN	Northwell In-system	United Healthcare In-UHC network	Out-of-Network <i>reimbursement = 140% of Medicare. Participant pays the difference between United Healthcare payment and the provider charges.</i>
Home Healthcare (1)	100% covered	100% covered 200 visits max per calendar year	Deductible/50% Coinsurance 200 visits max per calendar year
Home Infusion Therapy	100% covered	Deductible/30% Coinsurance	Deductible/50% Coinsurance
Home Infusion Therapy OOA Plan	100% covered	100% covered	Deductible/50% Coinsurance
Hospice Care	100% covered/ No copay	Deductible/ 30% Coinsurance	Deductible/ 50% Coinsurance
Outpatient Surgery, Pre-surgical Testing, Anesthesia	100% covered/ No copay	Deductible/ 30% Coinsurance	Deductible/ 50% Coinsurance
Chemotherapy, Radiation	100% covered/ No copay	Deductible/ 30% Coinsurance	Deductible/ 50% Coinsurance
Lab Tests, X-Rays, MRI, MRA, CAT, PET and Nuclear Scans	100% covered/ No copay	Deductible/ 30% Coinsurance	Deductible/ 50% Coinsurance
Artificial Insemination	100% covered, no lifetime max	Deductible/ 30% Coinsurance	Deductible/ 50% Coinsurance
Assisted Reproductive Technology	80% covered up to 3 cycles/Lifetime at Northwell Fertility (2)	Not covered	Not covered
Third Party Reproduction (3)	Covered up to 30K per lifetime at Northwell Health Fertility (2)	Not covered	Not covered
Elective Egg Freezing	Covered up to \$8.5K per lifetime at Northwell Fertility (2)	Not covered	Not covered
Fertility Medication (4)	Covered with \$15K, lifetime max	Covered with \$15K, lifetime max	Covered with \$15K, lifetime max
Chiropractic Care	\$20 Specialist copay	Deductible/ 30% Coinsurance	Deductible/ 50% Coinsurance
Acupuncture	\$20 Specialist copay	Deductible/ 30% Coinsurance	Deductible/ 50% Coinsurance
Second Surgical Opinion	\$40 Specialist copay	Deductible/ 30% Coinsurance	Deductible/ 50% Coinsurance
Kidney Dialysis	100% covered/ No copay	Deductible/ 30% Coinsurance	Deductible/ 50% Coinsurance
Kidney Dialysis OOA Plan	100% covered/ No copay	100% covered/ No copay	Deductible/ 50% Coinsurance
Physical Therapy, Speech/Language, Occupational, Developmental Delay	100% covered/ No copay for all in-system facilities and IPA PTs only. (60 visits max annually)	\$20 copay (60 visits max annually)	Deductible/ 50% Coinsurance (60 visits max annually)
Substance Use	100% covered/ No copay	100% covered/ No copay	Deductible/50% Coinsurance

NORTHWELL HEALTH, HEALTH & WELFARE FLEX BENEFIT PROGRAM – SUMMARY PLAN DESCRIPTION

VALUE PLAN	Northwell In-system	United Healthcare In-UHC network	Out-of-Network <i>reimbursement = 140% of Medicare. Participant pays the difference between United Healthcare payment and the provider charges.</i>
Durable Medical Equipment	100% covered	100% covered	Deductible/50% Coinsurance
Prosthetics, Orthotics (when medically necessary)	100% covered	100% covered	Deductible/50% Coinsurance
Ambulance	100% covered	100% covered	100% covered
Inpatient Care			
Inpatient Hospital (as many days as medically needed)	100% covered	Deductible/30% Coinsurance/and \$1,250 per admission copay	Deductible/50% Coinsurance/and \$1,500 per admission copay
Inpatient Hospital (as many days as medically needed) Out-of-Area Plan	100% covered	Deductible/30% Coinsurance	Deductible/50% Coinsurance/and \$1,500 per admission copay
Surgery, Surgical Assistance, Anesthesia	100% covered	Deductible/ 30% Coinsurance	Deductible/50% Coinsurance
Skilled Nursing Facility (60 days max per calendar year)	100% covered	Deductible/ 30% Coinsurance	Deductible/50% Coinsurance
Mental Health			
Outpatient	\$20 Copay	\$20 Copay	Deductible/50% Coinsurance
Inpatient Substance Use Rehab	100% covered	100% covered	Deductible/50% Coinsurance
Inpatient Substance Use Detox	100% covered	100% covered	Deductible/50% Coinsurance

Notes:

- Coinsurance amounts are off of UnitedHealthcare's contracted rates with providers.
- Reimbursement schedule varies. Participant pays the difference between United Healthcare payment and the provider charges. If you go out-of-network you may incur very high out of pocket expenses.
- Complete Summary Plan Descriptions of all plans are available on the employee intranet - search benefits.

(1) Home Healthcare- must be ordered by a physician, provided by or supervised by a registered nurse. Custodial Care and Domiciliary Care are not covered.

(2) Northwell Health Fertility is located at 300 Community Drive, Manhasset.

(3) Third Party Reproduction is not administered by UHC. Please contact Northwell Health Fertility at 516-562-2229 for more information.

(4) Fertility Medication must go through Vivo Health

NORTHWELL HEALTH, HEALTH & WELFARE FLEX BENEFIT PROGRAM — SUMMARY PLAN DESCRIPTION

BUY-UP PLAN	Northwell In-system	United Healthcare In-UHC network	Out-of-Network <i>reimbursement = 140% of Medicare. Participant pays the difference between United Healthcare payment and the provider charges.</i>
Deductible	\$0	\$750 Individual/ \$1,500 Family	\$2,500 Individual/ \$5,000 Family
Deductible Out-of-Area (OOA) Plan	\$0	\$500 Individual/ \$1,000 Family	\$1,000 Individual/ \$2,000 Family
Cardiac and Orthopedic Deductible (OOA Plan excluded)	\$0	\$5,750 Individual/ \$11,500 Family	\$8,500 Individual/ \$17,000 Family
Cardiac and Orthopedic Deductible Out-of-Area Plan	\$0	\$500 Individual/ \$1,000 Family	\$1,000 Individual/ \$2,000 Family
Coinsurance		10%	40%
Coinsurance OOA Plan		10%	30% (applies to all OOA out-of-network benefits)
Out-of-Pocket Max (includes deductibles, coinsurance/copays)	\$5,000 Individual / \$10,000 Family	\$5,750 Individual/ \$11,500 Family	\$8,500 Individual/ \$17,000 Family
Hospital Copay	\$0	\$1,250 per admission Deductible/10% Coinsurance	\$1,500 per admission Deductible/40% Coinsurance
Hospital Copay OOA Plan	\$0	No Copay Deductible/10% Coinsurance	\$1,250 Per Admission Deductible/30% Coinsurance
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Home/Office/Outpatient Care			
Preventive Care -Annual Exams -Immunizations	100% covered	Deductible/10% Coinsurance	Deductible/40% Coinsurance
Preventive Care OOA Plan -Annual Exams -Immunizations	100% covered	Deductible/10% Coinsurance	Deductible/40% Coinsurance
Office Visits	\$20 Primary Care \$40 Specialist copay	Deductible/10% Coinsurance	Deductible/40% Coinsurance
Office Visits For OOA	\$20 Primary Care/ \$40 Specialist copay	\$20 Primary Care/ \$40 Specialist copay	Deductible/30% Coinsurance
Emergency Room Visit	\$200 Copay (waived if admitted within 24 hrs)	\$200 Copay (waived if admitted within 24 hrs)	\$200 Copay (waived if admitted within 24 hrs)
Urgent Care	\$20 copay at GoHealth, ProHEALTH, PM Pediatrics & CareMount	\$60 copay	Deductible/40% Coinsurance

NORTHWELL HEALTH, HEALTH & WELFARE FLEX BENEFIT PROGRAM – SUMMARY PLAN DESCRIPTION

BUY-UP PLAN	Northwell In-system	United Healthcare In-UHC network	Out-of-Network <i>reimbursement = 140% of Medicare. Participant pays the difference between United Healthcare payment and the provider charges.</i>
Maternity Care (OOA Plan included)	100% covered	\$20 copay for Office Visit (first visit only) For Delivery Deductible/Coinsurance and hospital copay (waived for OOA)	Deductible/40% Coinsurance and hospital copay
Home Healthcare (1)	100% covered	100% Covered 200 visits max per calendar year	Deductible/40% Coinsurance/ 200 visits max per calendar year
Home Infusion Therapy	100% covered	Deductible/10% Coinsurance	Deductible/40% Coinsurance
Home Infusion Therapy OOA Plan	100% covered	100% covered	Deductible/40% Coinsurance
Hospice Care	100% covered/ No copay	Deductible/ 10% Coinsurance	Deductible/ 40% Coinsurance
Outpatient Surgery, Pre-surgical Testing, Anesthesia	100% covered/ No copay	Deductible/ 10% Coinsurance	Deductible/ 40% Coinsurance
Chemotherapy, Radiation	100% covered/ No copay	Deductible/ 10% Coinsurance	Deductible/ 40% Coinsurance
Lab Tests, X-Rays, MRI, MRA, CAT, PET and Nuclear Scans	100% covered/ No copay	Deductible/ 10% Coinsurance	Deductible/ 40% Coinsurance
Artificial Insemination	100% covered, no lifetime max	Deductible/ 10% Coinsurance	Deductible/ 40% Coinsurance
Assisted Reproductive Technology	80% Covered up to 3 cycles/Lifetime at Northwell Health Fertility (2)	Not covered	Not covered
Third Party Reproduction (3)	Covered up to 30K per lifetime at Northwell Health Fertility (2)	Not covered	Not covered
Elective Egg Freezing	Covered up to \$8.5K per lifetime at Northwell Health Fertility (2)	Not covered	Not covered
Fertility Medication (4)	Covered with \$15K, lifetime max	Covered with \$15K, lifetime max	Covered with \$15K, lifetime max
Chiropractic Care	\$20 Specialist copay	Deductible/ 10% Coinsurance	Deductible/ 40% Coinsurance
Acupuncture	\$20 Specialist copay	Deductible/ 10% Coinsurance	Deductible/ 40% Coinsurance
Second Surgical Opinion	\$40 Specialist copay	Deductible/ 10% Coinsurance	Deductible/ 40% Coinsurance

NORTHWELL HEALTH, HEALTH & WELFARE FLEX BENEFIT PROGRAM — SUMMARY PLAN DESCRIPTION

BUY-UP PLAN	Northwell In-system	United Healthcare In-UHC network	Out-of-Network <i>reimbursement = 140% of Medicare. Participant pays the difference between United Healthcare payment and the provider charges.</i>
Kidney Dialysis	100% covered/ No copay	Deductible/ 10% Coinsurance	Deductible/ 40% Coinsurance
Kidney Dialysis OOA Plan	100% covered/ No copay	100% covered/ No copay	Deductible/ 40% Coinsurance
Physical Therapy, Speech/Language, Occupational, Developmental Delay	100% covered/ No copay for all in-system facilities and IPA PTs only. (60 visits max annually)	\$20 copay (60 visits max annually)	Deductible/ 40% Coinsurance (60 visits max annually)
Substance Use	100% covered/ No copay	100% covered/ No copay	Deductible/40% Coinsurance
Durable Medical Equipment	100% covered	100% covered	Deductible/40% Coinsurance
Prosthetics, Orthotics -when medically necessary	100% covered	100% covered	Deductible/40% Coinsurance
Ambulance	100% covered	100% covered	100% covered
Inpatient Care			
Inpatient Hospital (as many days as medically needed)	100% covered	Deductible/10% Coinsurance/and \$1,250 per admission copay	Deductible/40% Coinsurance/and \$1,500 per admission copay
Inpatient Hospital (as many days as medically needed) OOA Plan	100% covered	Deductible/10% Coinsurance	Deductible/30% Coinsurance/and \$1,250 per admission copay
Surgery, Surgical Assistance, Anesthesia	100% covered	Deductible/ 10% Coinsurance	Deductible/40% Coinsurance
Skilled Nursing Facility (60 days max per calendar year)	100% covered	Deductible/ 10% Coinsurance	Deductible/40% Coinsurance
Mental Health			
Outpatient	\$20 Copay	\$20 Copay	Deductible/40% Coinsurance
Inpatient Substance Use Rehab	100% covered	100% covered	Deductible/40% Coinsurance
Inpatient Substance Use Detox	100% covered	100% covered	Deductible/40% Coinsurance

Notes:

- Coinsurance amounts are off of UnitedHealthcare's contracted rates with providers.
- Reimbursement schedule varies. Participant pays the difference between United Healthcare payment and the provider charges. If you go out-of-network you may incur very high out of pocket expenses.
- Complete Summary Plan Descriptions of all plans are available on the employee intranet - search benefits.

NORTHWELL HEALTH, HEALTH & WELFARE FLEX BENEFIT PROGRAM — SUMMARY PLAN DESCRIPTION

- (1) *Home Healthcare- must be ordered by a physician, provided by or supervised by a registered nurse. Custodial Care and Domiciliary Care are not covered.*
- (2) *Northwell Health Fertility is located at 300 Community Drive, Manhasset.*
- (3) *Third Party Reproduction is not administered by UHC. Please contact Northwell Health Fertility at 516-562-2229 for more information.*
- (4) *Fertility Medication must go through Vivo Health.*

Hospital Pre-Certification Applies to Northwell Health Value and Buy-Up Plans

The medical plan requires pre-certification before you are admitted to a hospital. To receive the maximum hospital benefits under your medical plan, you or your primary care physician must call the carrier's pre-certification telephone number to pre-certify your hospital admission. You may have to pay a penalty if you use a non-network physician and do not receive authorization from your medical plan. The pre-certification phone number is **888-254-3698**.

All Notification Requirements apply only to services and supplies obtained from Non-Network providers. There are no Notification Requirements when services and supplies are obtained from In-System or UHC Network Providers.

*Note: By enrolling in a Northwell health plan your enrolled dependents and you may be contacted by a service provider (may be a Northwell Health employee,) offering information, support or assistance, related to the usage of plan benefits. Your participation is entirely voluntary.

Plan Features	Northwell Health In-System	UHC In-Network	Non-Network
Lifetime Maximum Benefit 3 There is no dollar limit to the amount the Plan will pay for essential Benefits while you are enrolled in the Plan.	Unlimited	Unlimited	Unlimited

NORTHWELL HEALTH, HEALTH & WELFARE FLEX BENEFIT PROGRAM — SUMMARY PLAN DESCRIPTION

¹In addition to these Copays, you may be responsible for meeting the Annual Deductible for the Covered Health Services described in the chart on the following pages. With the exception of Emergency Health Services, Copay does not apply when you visit a Non-Network provider.

²Copays do not apply toward the Annual Deductible. The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

³Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:
Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The following charts apply to both the Value and Buy-Up Plans. For details, see the Value and Buy-Up charts above.

Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
Acupuncture Services (Copay is per visit) Northwell Health In-System: Up to 48 visits per calendar year UHC In-Network & Non-Network: Any combination of Network Benefits and non-Network Benefits are limited to 48 visits per calendar year	100% Covered after you pay a \$20 Copay	Deductible/Coinsurance	Deductible/Coinsurance
Ambulance Services <ul style="list-style-type: none"> Emergency Ambulance 	100% Covered	100% Covered	100% Covered

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
<ul style="list-style-type: none"> Non-Emergency Ambulance 	100% Covered	100% Covered	100% Covered
Botox, not covered when provided for cosmetic purposes	100% for Hyperhydrosis and Migraine/ brain conditions	Deductible/ Coinsurance for Hyperhydrosis and Migraine/ brain conditions	Deductible/ Coinsurance for Hyperhydrosis and Migraine/ brain conditions
Cancer Resource Services (CRS)* <ul style="list-style-type: none"> Hospital Inpatient Stay (Copay is per admission) 	100% Covered	Deductible/ Coinsurance after you pay \$1,250 Copay No copay for Out-of-Area, Deductible and Coinsurance apply	Not Covered
Congenital Heart Disease (CHD) Surgeries <ul style="list-style-type: none"> Hospital - Inpatient Stay (Copay is per admission) 	100% Covered	Deductible/ Coinsurance after you pay \$1,250 copay No copay for Out-of-Area, Deductible and Coinsurance apply	50% after you pay a \$1,500 (\$1,250 for Out-of-Area plan) Copay and after you meet the Annual Deductible
Dental Services - Accident Only	100% Covered	Deductible/ Coinsurance	Deductible/ Coinsurance

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
Diabetes Services Diabetic Equipment covered under the Medical Plan includes Glucose Meters & External Insulin Pumps.	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.
Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care <ul style="list-style-type: none"> • insulin pumps • diabetes supplies • See Durable Medical Equipment in <i>Additional Coverage Details Under the Value and Buy-Up Plans</i> , for limits	Benefits for diabetes equipment will be the same as those stated under <i>Durable Medical Equipment</i> in this section.	Benefits for diabetes equipment will be the same as those stated under <i>Durable Medical Equipment</i> in this section.	Benefits for diabetes equipment will be the same as those stated under <i>Durable Medical Equipment</i> in this section.

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
Durable Medical Equipment (DME) <i>See Additional Coverage Details, for limits.</i> Northwell Health In-System, UHC In-Network and Non-Network: Medical Supplies Covered Items: All Catheters, Dressings, and Compressions stockings All disposable medical supplies are covered	100% Covered	100% Covered	Deductible/ Coinsurance
Emergency Health Services - Outpatient If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay this Copay.	100% Covered after you pay a \$200 Copay	100% Covered after you pay a \$200 Copay	100% after you pay a \$200 Copay
Home Health Care	100% Covered	100% Covered	Deductible/ Coinsurance
Hospice Care 210 days limit per calendar year for In-Network and Non-Network Only	100% Covered	Deductible/ Coinsurance	Deductible/ Coinsurance
Hospital - Inpatient Stay (Copay applies per admission)	100% Covered No limit on number of days	Deductible/ Coinsurance after you pay a \$1,250 Copay	Deductible/ Coinsurance after you pay a \$1,500 Copay

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In- System	UHC In-Network	Non-Network
		No copay for Out-of-Area plans, Deductible and Coinsurance apply	(\$1,250 for Out-of-Area plan)
Infant Formula Up to \$2,500 per calendar year. <i>See Additional Coverage Details Under the Value and Buy-Up Plans, for limits.</i>	100% Covered	100% Covered	100% Covered

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
Infertility Services <i>See Additional Coverage Details Under the Value and Buy-Up Plans, for limits.</i>	80% for up to 3 cycles per lifetime	Not Covered	Not Covered
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	100% Covered	Deductible/Coinsurance	Not Covered
Lab, X-Ray and Diagnostics – Outpatient	100% Covered	Deductible/Coinsurance	Deductible/Coinsurance
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine – Outpatient	100% Covered	Deductible/Coinsurance	Deductible/Coinsurance
Mental Health Services <ul style="list-style-type: none"> Hospital - Inpatient Stay/Outpatient 	100% Covered	100% Covered	Deductible/Coinsurance

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
Neurobiological Disorders - Autism Spectrum Disorder Services <ul style="list-style-type: none"> Hospital - Inpatient Stay Physician's Office Services (Copay is per visit) 	100% Covered 100% Covered after you pay a \$20 Copay Deductible	100% Covered 100% after you pay a \$20 Copay	Deductible/Coinsurance Deductible/Coinsurance
Nutritional Counseling Nutritional Counseling is covered for any diagnosis. (Copay is per visit)	100% Covered after you pay a \$20 Physician Copay/\$40 Specialist Copay No copayment applies when a Physician charge is not assessed.	Deductible/Coinsurance (4 office visits annual max)	Deductible/Coinsurance
Diabetes counseling	100% Covered		

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
Obesity Surgery <ul style="list-style-type: none"> Physician's Office Services (Copay is per visit) Physician Fees for Surgical and Medical ~ Hospital - Inpatient Stay (Copay is per visit) <p><i>See Additional Coverage Details Under the Value and Buy-Up Plans, for limits</i></p>	<p>100% Covered after you pay a \$20 Physician Copay/\$40 Specialist Copay</p> <p>No copayment applies when no Physician charge is assessed.</p> <p>100% Covered</p> <p>100% Covered</p>	<p>Deductible/Coinsurance</p> <p>Deductible/Coinsurance</p> <p>Deductible/Coinsurance after you pay a \$1,250 Copay</p> <p><i>No copay for Out-of-Area plans, Deductible and Coinsurance apply</i></p>	<p>Deductible/Coinsurance</p> <p>Deductible/Coinsurance</p> <p>Deductible/Coinsurance after you pay a \$1,500 Copay (\$1,250 for Out-of-Area plan)</p>
Ostomy Supplies	100% Covered	100% Covered	Deductible/Coinsurance
Pharmaceutical Products – Outpatient	100% Covered	Deductible/Coinsurance	Deductible/Coinsurance

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In- System	UHC In-Network	Non-Network
Physician Fees for Surgical and Medical Services	100% Covered	Deductible/ Coinsurance	Deductible/ Coinsurance

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
Physician's Office Services - Sickness and Injury <ul style="list-style-type: none"> Primary Physician (Copay is per visit) (No copayment applies when no Physician charge) Specialist Physician (Copay is per visit) (No copayment applies when no Physician charge) Home Visit: 100% Covered <p>In addition to the Copay stated in this section, the Copays and Coinsurance and any Deductible for the following services apply when the Covered Health Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine 	<p>100% Covered after you pay a \$20 Copay</p> <p>100% after you pay a \$40 Copay</p> <p>Home Visit: 100% Covered</p>	<p>Deductible/Coinsurance</p> <p>Deductible/Coinsurance</p>	<p>Deductible/Coinsurance</p> <p>Deductible/Coinsurance</p>

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
<ul style="list-style-type: none"> • Pharmaceutical Products – Outpatient • Scopic Procedures - Outpatient Diagnostic • Surgery – Outpatient Therapeutic Treatments – Outpatient 			
<p>Pregnancy – Maternity Services</p> <p>A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</p>	Benefits will be the same as those stated under each Covered Health Service category in this section.	<p>Benefits will be the same as those stated under each Covered Health Service category in this section.</p> <p>The Per Confinement Deductible will not apply for Sick Newborns who remain confined after the mother is discharged for up to 90 days</p>	<p>Benefits will be the same as those stated under each Covered Health Service category in this section.</p> <p>The Per Confinement Deductible will not apply for Sick Newborns who remain confined after the mother is discharged for up to 90 days</p>

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
Preventive Care Services <ul style="list-style-type: none"> Physician Office Services 	100% Covered	Deductible/Coinsurance	Deductible/Coinsurance
<ul style="list-style-type: none"> Breast Pumps 	100% Covered	100% Covered	Deductible/Coinsurance
<ul style="list-style-type: none"> Lab, X-ray or Other Preventive Tests 	100% Covered	100% Covered	Deductible/Coinsurance
Prosthetic Devices	100% Covered	100% Covered	Deductible/Coinsurance
Reconstructive Procedures	Same as: Physician's Office Services	Same as: Physician's Office Services – Sickness and Injury	Same as: Physician's Office Services – Sickness and Injury

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
	– Sickness and Injury Physician Fees Hospital-Inpatient Stay Surgery - Outpatient Lab, X-ray and Diagnostics – Outpatient Therapeutic Treatments - Outpatient	Physician Fees Hospital-Inpatient Stay Surgery - Outpatient Lab, X-ray and Diagnostics – Outpatient Therapeutic Treatments - Outpatient	Physician Fees Hospital-Inpatient Stay Surgery - Outpatient Lab, X-ray and Diagnostics – Outpatient Therapeutic Treatments - Outpatient
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment (Copay is per visit) <i>See Additional Coverage Details Under the Value and Buy-Up Plans, for visit limits</i>	100% Covered 60 visits annual max	Deductible/Coinsurance Physical and Occupational Therapy: 100% after you pay a \$20 Copay 60 visits annual max	Deductible/Coinsurance 60 visits annual max
Refractive Eye Exam (with medical diagnosis only)	100% Covered	Deductible/Coinsurance	Deductible/Coinsurance
Scopic Procedures - Outpatient Diagnostic and Therapeutic	100% Covered	Deductible/Coinsurance	Deductible/Coinsurance
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services	100% Covered	Deductible/Coinsurance	Deductible/Coinsurance

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
Northwell Health In-System: Up to 60 days per calendar year UHC In-Network & Non-Network: Up to 60 visits per calendar year			
Substance Use Disorder Services- see Mental Health			
Surgery - Outpatient	100% Covered	Deductible/Coinsurance	Deductible/Coinsurance
Temporomandibular Joint Syndrome (TMJ)	100% Covered	N/A	N/A
Therapeutic Treatments - Outpatient	100% Covered	Deductible/Coinsurance	Deductible/Coinsurance
Treatment of Gender Identity Disorder/Dysphoria	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.
Transplantation Services	Depending upon where the Covered Health Services is provided, Benefits for	Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the	Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
	transplantation services will be the same as those stated under each Covered Health Services category in this section.	same as those stated under each Covered Health Services category in this section. <i>Deductible/Coinsurance</i>	same as those stated under each Covered Health Services category in this section. <i>Deductible/Coinsurance</i>
Travel and Lodging (If services rendered by a Designated Facility)		For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures	
Urgent Care Center Services (Copay is per visit) In addition to the Copay stated in this section, the Copays and Coinsurance and any Deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center:	100% Covered after you pay a \$20 Copay	100% Covered after you pay a \$60 Copay	Deductible/Coinsurance
<ul style="list-style-type: none"> Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and 	100% Covered	Deductible/Coinsurance	Deductible/Coinsurance

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Value and Buy-Up Plan Covered Health Services	Percentage of Eligible Expenses Payable by the Plan:		
	Northwell Health In-System	UHC In-Network	Non-Network
Nuclear Medicine – Outpatient <ul style="list-style-type: none"> Pharmaceutical Products – Outpatient Scopic Procedures - Outpatient Diagnostic Surgery – Outpatient Therapeutic Treatments – Outpatient 			
Wigs	100% Covered	100% Covered	100% Covered

*These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services, Physician Fees for Surgical and Medical Services, Hospital - Inpatient Stay, Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic Lab, X-Ray and Diagnostics – Outpatient, and Lab, X-Ray and Major Diagnostics – CT, PET, MRI, MRA and Nuclear Medicine – Outpatient.*

ADDITIONAL COVERAGE DETAILS UNDER THE VALUE AND BUY-UP PLANS**What this section includes:**

- Covered Health Services for which the Plan pays Benefits

This section supplements the tables in *Value and Buy-Up Medical Plan Highlights*.

While the table provides you with Benefit limitations along with copayment, Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the

Benefits. These descriptions include any additional limitations that may apply. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in *Exclusions*.

Acupuncture Services

The Plan pays for acupuncture services for pain therapy provided that the service is performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine;
- Doctor of Osteopathy;
- Chiropractor; or
- Acupuncturist.

Covered Health Services include treatment by acupuncture of nausea as a result of:

- chemotherapy;
- Pregnancy; and
- post-operative procedures.

Northwell Health: Benefits are limited up to 48 visits per calendar year.

UHC In-Network & Non-Network: Any combination of In-Network Benefits and Non-Network Benefits are limited up to 48 treatments per calendar year.

Did you know...

You generally pay less out-of-pocket when you use an In-System provider in the IPA?

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a Non-Network Hospital to a In-Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;

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- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by the Clinical Call Center;
- call CRS toll-free at 1-866-936-6002; or
- visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with cancer-related services received at a Designated Facility.

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and

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the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);
- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient.

Please remember for Non-Network Benefits, you must notify United Resource Networks as soon as CHD is suspected or diagnosed.

Note: The services described under *Travel and Lodging* are Covered Health Services only in connection with CHD services received at a Congenital Heart Disease Resource Services program.

Continuation of Care Rules for Cardiac and Orthopedic Plan Changes Effective July 1, 2018

If you're currently under the care of a cardiologist or orthopedist that is outside of Northwell Health's system, meaning they are not a member of Northwell's Clinical Integration Independent Physician Association (CIIPA), there are identified rules and criteria that will prevent you from being affected by the increased deductible.

General Rules for Orthopedics - You can continue to use a non-Northwell/out-of-system provider without paying a new higher deductible if you're experiencing one or more of the following:

- Completed procedures with complications: can keep existing non-Northwell provider for six months (until 12/31/2018); 12 months for non-superficial infections (until 6/30/19)
- Joint reconstructions: can keep existing non-Northwell provider for 12 months post-op (until 6/30/19)
- Shoulder reconstruction: can keep existing non-Northwell provider for 12 months post-op (until 6/30/19)
- Elective orthopedics: can keep existing non-Northwell provider for 12 months post-op (until 6/30/19)
- Tumor orthopedics: can keep existing non-Northwell provider if had a tumor as a teenager - if adult, for 12 months (until 6/30/19)
- Trauma: Pediatrics can keep existing non-Northwell provider for 12 months post-op (to 6/30/19)
- Adult can keep existing non-Northwell provider for accidents, falls and fractures for 12 months post-op (until 6/30/19)
- Other orthopedic surgeries: can keep existing non-Northwell provider for 12 months (until 6/30/19)
- Surgeries scheduled prior to 7/1/18 can keep existing non-Northwell provider for 12 months (until 6/30/19)

General Rules for Cardiology - Important information about the criteria includes:

- Patients who had a heart transplant or a heart pump (LVAD) surgery have no time limit on how long they can keep their non-Northwell provider
Patients who had evaluations for heart transplant or a heart pump surgery and do not change the provider to a Northwell provider will pay the new higher deductible – the plan provides coverage for transportation for surgeries and follow-up
- Advanced heart failure can be treated at Long Island Jewish Medical Center, Lenox Hill and Manhasset hospitals by advanced heart clinicians (Staten Island University Hospital and Southside Hospital will soon follow)
As of July, 2019 there will be such providers in Westchester but for now employees who reside in Eastern Long Island and Westchester will not pay the new deductible only if they need to use the advanced heart clinician provider
- Regular cardiologist visits: those who are in treatment or those in a process of being evaluated will be charged the new higher deductible if they do not change to Northwell in-system provider
- Dual transplants: these patients can keep existing providers, with no time limit

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- AFIB Ablation: these patients can keep existing non-Northwell provider for 12 months (until 6/30/19) - repeat ablations may be needed
- Complex Arrhythmia cases: these patients can keep existing non-Northwell provider for six months (until 12/31/18)
- Other implemented devices (pacemaker, defibrillator): if implanted prior to 7/1/18, patients can keep existing non-Northwell provider (through 10/31/18)

Dental Services - Accident Only

Tooth/teeth do not need to be sound and natural Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immune-suppressive (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

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Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	<p>Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.</p> <p>Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.</p>
Diabetic Self-Management Items	<p>Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person including:</p> <ul style="list-style-type: none"> • blood glucose monitors; • insulin syringes with needles; • blood glucose and urine test strips; • ketone test strips and tablets; • Omnipods and • lancets and lancet devices. <p>Insulin pumps are subject to all the conditions of coverage stated under <i>Durable Medical Equipment</i> in this section.</p> <p>Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under <i>Durable Medical Equipment</i> in this section.</p>

Disease Management Program

To help participants best manage their condition, blood glucose levels, risk factors, reduce unnecessary emergency room visits, and prevent disease progression and other illnesses related to poorly managed diabetes.

- Provide the information and resources participants need to:
 - Understand their condition, its implications, and how to reduce or eliminate risk factors such as high cholesterol, high blood pressure, excess weight, obesity, smoking, and lack of physical activity
 - Maintain a healthy lifestyle and adhere to physician treatment plans and medication regimens
 - Effectively manage their condition and co-morbidities, including depression
 - Receive the most clinically appropriate, cost-effective and timely diagnostic testing and procedures
- Registered nurses determine the appropriate level of **intervention**
 - Based on guidelines established by the American Diabetes Association (ADA)
- A personalized **program** to help reduce risk factors, including high cholesterol, high blood pressure, excess weight, obesity and smoking
- A focus on **adherence** to medication regimens and physician treatment plans
- **Comprehensive member education** to enable and improve self-care skills and recognition of symptoms
- In conjunction with treating physician, guide members to receive the most clinically-appropriate, cost-effective and timely diagnostic testing and procedures such annual eye and foot exams
- Medical director **oversight** to monitor adherence to national evidence-based medicine guidelines
- Information provided about risk factors and co-morbidities including hypertension and depression
- Nurses may send additional materials or links to resources

- Scheduled calls with a nurse based on the member's needs. Members may call their nurse at any time via his/her direct line.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;
- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay, Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair after three years with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at anytime and are not subject to the three year timeline for replacement.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

If you are admitted as an inpatient to a Hospital directly from the Emergency room, you will not have to pay the Copay for Emergency Health Services. The Benefits for an Inpatient Stay in an In-Network Hospital will apply instead.

Network Benefits will be paid for an Emergency admission to a Non-Network Hospital. If you continue your stay in a Non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to an In-Network Hospital, Non-Network Benefits will apply.

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse non family member.

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- not considered Custodial Care, as defined in *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to *Glossary* for the definition of Skilled Care.

Skilled Care is determined to be needed after reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Northwell Health In-System: Benefits are not limited to any number of visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

UHC In-Network & Non-Network: Any combination of In-Network Benefits and Non-Network Benefits are limited up to 200 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Northwell Health In-System: Benefits are not limited to visits per calendar year.

UHC In-Network & Non-Network: Any combination of In-Network Benefits and Non-Network Benefits are limited up to 210 visits per calendar year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Infant Formula

Coverage is provided for specialized, non-standard infant formula when the covered infant's physician has determined such formula to be medically necessary for the child.

The employee will need to submit:

- Letter stating the medical necessity and the name of the formula;
- Legible receipts of purchase clearly showing date of purchase, item description and purchase price; and
- UHC claim form with member section completed and signed/dated.

Any combination of In-Network Benefits and Non-Network Benefits are limited up to \$2,500 per calendar year.

Infertility Services (Northwell Health In-System Only)

All services are provided at Northwell Health Fertility locations. The egg retrieval and embryo transfers are performed in the Manhasset location. Note: NYC office is located at 110 E. 59th Street, Suite 10D.

The plan covers:

- Pre-implantation Genetic Diagnosis (PGD) and pre-implantation genetic screening embryo(s) (PGS). Requires medical director approval.
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA)-male factor associated surgical procedures for retrieval of sperm;
- Fertility preservation for cancer patients;
- Pharmaceutical Products for the treatment of infertility that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office or in a Covered Person's home.

Embryo and specimen transportation

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Treatment of infertility for

- ovulation induction and controlled ovarian stimulation;
- insemination procedures (artificial insemination (AI) and intrauterine insemination (IUI));
- Assisted Reproductive Technologies (ART), including but not limited to, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT); and Intra Cytoplasmic Sperm Injection (ICSI);
- Fertility preservation
- Cryopreservation of embryos

Northwell Health In-System: IVF, GIFT, ZIFT are limited up to 3 cycles per Covered Person during the entire period you are covered under the Plan. A cycle includes implant transfer procedure. One transfer equals one cycle.

Plan Coverage	In-system	United Network	Out-of network
Artificial Insemination	100% covered at any IPA, no lifetime max	Deductible/Coinsurance	Deductible/Coinsurance
Assisted Reproductive Technology	80% Covered up to 3 cycles/Lifetime at CHR	Not Covered	Not Covered
Fertility Medication	Covered with \$15K, lifetime max	Covered with \$15K, lifetime max	Covered with \$15K, lifetime max

Assisted Reproductive Benefit (as of 1/1/18)

- \$8K payment to donor + \$22K payment for donor egg cycle, totaling \$30K lifetime payment per utilizer
- Eligibility is 1 year waiting period from date of hire, infertility reasons and same sex couples

Administered via Northwell Health Human Reproduction Department, payment is a taxable income, administered outside of medical plan. This benefit is not a medical expense under UnitedHealthcare.

Covered items:

- agency fees
- screening (FDA and psychological) and background check expenses

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- gestational surrogate benefit: medical, medications, IVF monitoring procedure costs
- in-vitro fertilization transfer payments
- egg donor compensation
- attorneys' fees and costs
- licensed social worker support fees
- other expenses directly related to, and for the principal purpose of, having an eligible Assisted Reproductive service for an eligible Employee

Egg Freezing

Benefit is an \$8,000 initial benefit plus \$500 for the first year only for storage.

Cryopreservation is a covered benefit up to age 45 with one year of storage regardless of diagnosis. Cryopreservation is also covered with no limit on storage for Oocyte, ovarian tissue, embryo cryopreservation for women who are at risk of infertility due to gonadotoxic therapies such as chemotherapy or radiation therapy.

- Benefit is administered by United Healthcare
- Must be employed one year
- Available to non-union employees only
- One of partners must be a Northwell employee and must have Northwell medical coverage.
- Meds are included in \$15K lifetime
- MESA/tese storage not covered
- Cancer patients have yearly storage covered though In-Vitro coverage (80%)

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) disease provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the In-Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Clinical Call Center; or
- call KRS toll-free at 1-888-936-7246 and select the KRS prompt.

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To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- Physician's Office Services - Sickness and Injury;
- Physician Fees for Surgical and Medical Services;
- Scopic Procedures - Outpatient Diagnostic and Therapeutic;
- Therapeutic Treatments - Outpatient;
- Hospital - Inpatient Stay; and
- Surgery - Outpatient

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- lab and radiology/x-ray; and
- mammography.
- Benefits under this section include:
 - the facility charge and the charge for supplies and equipment; and
 - Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness. You will be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways

as described in the program. **Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.**

Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorders

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders):

Provided by or under the direction of a qualified psychiatrist and/or a licensed psychiatric provider

- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others
- and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Nutritional Counseling

Nutritional Counseling is covered for any diagnosis.

The Plan will pay for Covered Health Services for medical education services provided in a Physician's office by an appropriately licensed or healthcare professional when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Some examples of such medical conditions include:

- coronary artery disease;
- congestive heart failure;
- severe obstructive airway disease;
- gout (a form of arthritis);
- renal failure;
- phenylketonuria (a genetic disorder diagnosed at infancy); and
- hyperlipidemia (excess of fatty substances in the blood).

When nutritional counseling services are billed as a preventive care service, these services will be paid as described under *Preventive Care Services* in this section.

Obesity Surgery

The Plan covers surgical treatment of obesity provided by or under the direction of a Physician provided either of the following are true:

- you have a minimum Body Mass Index (BMI) of 40; or
- you have a minimum BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by obesity
-

Benefits are available for obesity surgery services that meet the definition of a Covered Health Service, as defined in *Glossary* and are not Experimental or Investigational or Unproven Services.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and

- skin barriers

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility. Specialty RX administered in physician's office must be submitted to RX vendor. Deductible and coinsurance will be applied for any office/surgical procedures if service is performed in and out of network.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Benefits under this section include lab, radiology/x-ray or other diagnostic services performed in the Physician's office. Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/x-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

Please Note

Your Physician does not have a copy of your PD/SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Healthy moms and babies

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

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- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under *Medical Plan Highlights*, under *Covered Health Services*.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

For questions about your preventive care Benefits under this Plan call 1-888-254-3698.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at 1-888-254-3698 for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures and complication from cosmetic procedures unless life threatening are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;

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- occupational therapy, including Cognitive rehabilitation therapy following a post- traumatic brain injury or cerebral vascular accident;
- Manipulative Treatment;
- speech therapy, covered for any diagnosis when prescribed by a physician;
- post-cochlear implant aural therapy;
- Vision therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- pulmonary rehabilitation; and
- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician, must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Northwell Health In-System: Benefits are limited to:

- 60 combined visits per calendar year for physical therapy, occupational therapy, post cochlear therapy, speech therapy and pulmonary rehabilitation; and
- 36 visits per calendar year for cardiac rehabilitation therapy

UHC In-Network: Benefits are limited to:

- Any combination of In-Network and Non-Network Benefits are limited as follows: 60 visits per calendar year for physical therapy, occupational therapy, post cochlear therapy, speech therapy and pulmonary rehabilitation; and
- 36 visits per calendar year for cardiac rehabilitation therapy

Non-Network: Benefits are limited to:

- Any combination of In-Network and Non-Network Benefits are limited as follows: 60 visits per calendar year for physical therapy, occupational therapy, post cochlear therapy, speech therapy and pulmonary rehabilitation; and
- 36 visits per calendar year for cardiac rehabilitation therapy

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

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- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;
- it is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or Domiciliary Care, even if ordered by a Physician, as defined in *Glossary*.

Northwell Health In-System: Benefits are limited up to 60 visits per calendar year.

UHC In-Network & Non-Network: Any combination of In-Network Benefits and Non-Network Benefits are limited up to 60 treatments per calendar year.

Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office.

Benefits include the following services:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management.
- Crisis intervention.
- Partial Hospitalization/Day Treatment;

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- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. You will be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. **Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory**

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists.

Please remember for Non-Network Benefits, you must notify the Personal Support. Please call the phone number that appears on your ID card. Without notification, Benefits will be subject to a \$500 reduction.

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Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services – Sickness & Injury*.

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a provider. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.

Benefits are also available for cornea transplants. You are not required to notify United Resource Networks of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

Contact United Resource Networks at 1-888-936-7246 for information and guidance.

Transplants that are performed in-system are bone marrow and kidney.

Travel and Lodging

United Resource Networks will assist the patient and family with travel and lodging arrangements related to:

- Congenital Heart Disease (CHD);
- transplantation services; and
- cancer-related treatments.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient if this is patient's primary coverage, and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the cancer-related treatment, the CHD service, or the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to \$50 per day for the patient or up to \$100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to \$100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility (for CRS and transplantation) or the CHD facility.

UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or

- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

Support in the event of serious illness

If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Treatment of Gender Identity Disorder/Dysphoria

The Plan pays Benefits for the treatment of Gender Identity Disorder/Dysphoria as follows:

- **Psychotherapy** for gender identity disorders/dysphoria and associated co-morbid psychiatric diagnoses as described under Mental Health Services in *Additional Coverage Details Under the Value and Buy-Up Plans*.
- **Continuous hormone replacement** - hormones of the desired gender injected by a medical provider.

Note. Coverage may be available for oral and self-injected hormones under the Prescription Drug Products portion of the Plan. See *Prescription Drug Plan*, for coverage details and exclusions.

- Genital Surgery and Surgery to Change Secondary Sex Characteristics (including Thyroid Chondroplasty, Bilateral Mastectomy, and Augmentation Mammoplasty).
 - The treatment plan must conform to the most recent edition of the *World Professional Association for Transgender Health (WPATH), Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People*, and
 - For irreversible surgical interventions, the patient must be age 18 years or older, and
 - Prior to surgery, the patient must complete 12 months of successful continuous full time real life experience in the desired gender, and

Important:

- Certain patients will be required to complete continuous hormone therapy prior to surgery. In consultation with the patient's physician, this will be determined on a case-by-case basis through the Prior Authorization process.
- Augmentation Mammoplasty is allowed if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role.
- **Laboratory testing** to monitor the safety of continuous hormone therapy.

The Claims Administrator has specific guidelines regarding Benefits for *Treatment of Gender Identity Disorder/Dysphoria*. Contact the Claims Administrator at the telephone number on your ID card for information about these guidelines.

The following services are added and now require you to contact the Claims Administrator to provide prior notification:

- *Treatment of Gender Identity Disorder/Dysphoria* is added to the list of services that require you to call the Claims Administrator, now described under is added to the list of services that require you to call the Claims Administrator, now described under *Treatment of Gender Identity Disorder/Dysphoria*, as follows:

- For Non-Network Benefits for Gender Dysphoria you must notify the Claims Administrator five business days before scheduled services are received or for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to notify the Claims Administrator as required, Benefits will be subject to a \$500 reduction.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section. One copay applies.

Wigs

The Plan pays Benefits for wigs and other scalp hair prosthesis for post chemotherapy and/or radiation therapy.

RESOURCES TO HELP YOU STAY HEALTHY**What this section includes:**

Health and well-being resources available to you, including:

- Disease and Condition Management Services; and
- Wellness Programs.

The resources described in this Section are available to employees enrolled in the UnitedHealthcare Value or Buy-Up medical options.

Northwell Health believes in giving you the tools you need to be an educated health care consumer. To that end, Northwell Health has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare, and Northwell Health are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools**Employee Assistance Program (EAP)**

UnitedHealthcare offers free counseling and referral services nationwide through the Employee Assistance Program (EAP). Using a solution focused approach to care, they tailor their interventions to meet your individual needs. The program can help you and your immediate family members cope with issues such as:

- family or relationship problems;
- parenting difficulties;
- work-related problems;
- financial and legal issues;
- substance use;

- grief and loss; and
- anxiety.

Call 1-888-254-3698 to speak to a specially trained, master's-level specialist who will recommend the right resources for your specific life concern. Services are available any time, 24 hours a day, seven days per week and are strictly confidential in accordance with state and federal laws.

Health Assessment

You are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call 1-888-254-3698.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – Northwell Health's way of helping you meet your health and wellness goals.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer;
- coronary disease and
- bariatric surgery.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please call 1-888-254-3698.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for In-Network providers available in your Plan through the online provider directory;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on *www.myuhc.com*

If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Copays and Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services***HealtheNotesSM***

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential

interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call 1-888-254-3698.

Care Management Services

The Plan offers care management services to help coordinate services for those with health care needs due to serious, complex, and/or chronic health conditions. Those services are provided by, or in conjunction with, Northwell Health's CareSolutions Department (or any successor Department) and in some cases, by other providers and vendors. Participation in the care management program is entirely voluntary. If you choose to participate, our programs coordinate services and provide education to help meet your health-related needs..

Our care management programs are confidential and voluntary. These programs are given at no extra cost to you and do not change covered services. If you meet program criteria and agree to take part, the Plan will help you meet your identified health care needs. This is reached through contact and team work with you and/or your authorized representative, treating physician(s), and other providers. In addition, the Plan may assist in coordinating care with existing community-based programs and services to meet your needs, which may include giving you information about external agencies and community-based programs and services.

In certain cases of what we consider severe or chronic (or potentially severe or chronic) illness or injury, we may, in our discretion administer benefits for alternate care through our care management program or other arrangement that is not listed as a covered service. We may also approve as covered extensions of covered services beyond the benefit maximums of this PD/SPD. We will make our decision on a case-by-case basis and on such terms and conditions as we deem appropriate, in our discretion.

Nothing in this provision shall prevent you from appealing the Plan's decision. A decision to provide extended benefits or approve alternate care in one case does not obligate the Plan to administer the same benefits again to you or to any other participant. The Plan reserves the right, at any time, to alter or stop administering extended benefits or approving alternate care.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling 1-888-254-3698. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call 1-888-254-3698.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

Maternity Support Program

If you are pregnant or thinking about becoming pregnant, and you are enrolled in the medical Plan, you can get valuable educational information, advice and comprehensive case management by calling 1-888-254-3698. Your enrollment in the program will be handled by an OB nurse who is assigned to you.

This program offers:

- enrollment by an OB nurse;
- pre-conception health coaching;
- written and online educational resources covering a wide range of topics;
- first and second trimester risk screenings;
- identification and management of at- or high-risk conditions that may impact pregnancy;

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- pre-delivery consultation;
- coordination with and referrals to other benefits and programs available under the medical plan;
- a phone call from a nurse approximately two weeks postpartum to provide information on postpartum and newborn care, feeding, nutrition, immunizations and more; and
- post-partum depression screening.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first trimester of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call 1-888-254-3698.

As a program participant, you can always call your nurse with any questions or concerns you might have.

Wellness Actions

Employees enrolled in the Northwell Health Value or Buy-up plan can participate by completing four wellness pledges in exchange for paycheck credits= \$1,040 for completing 4 healthy actions. (\$260 each action) The program runs annually, with wellness action compliance taking place the year before you are credited in your pay.

Here's how it works:

Once you enroll in the Northwell Plan in 2018, your 2018 credits you completed in 2017 will be automatically credited to your paycheck in cash and subject to W-2 withholdings. New hires will have six months from your January 1 benefits effective date to act on four wellness actions. If you do not act on the actions, your paycheck credits will cease on or about the six month grace period (June 30). By scheduling and acting on your health and preventive care actions throughout 2017 you will continue to earn credits in 2018.

Here's what you have to do:

Submit your online Health Risk Assessment (HRA) on the myWellness platform. You can find the HRA when registering and logging in to Northwell.edu/myWellness.

Completing your HRA is a **required** action in order for you to receive your credits. It is important you open your email notifications from the Department of Total Rewards. These emails will keep you up to speed on details of your benefits

Act on 3 more pledges to maximize your credits:

1. Physician Wellness Action: Your annual physical
2. Dental Exam Action: Exam or cleaning
3. Vision Exam Action: Eye exam by a licensed provider

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4. Breast Cancer Screening Action: Mammogram
5. Skin Cancer Screening Action: Full body skin check
6. Colorectal Cancer Screening Action: Colonoscopy
7. Cervical Cancer Screening Action: Pap smear
8. Feinstein GaP Registry Action: Visit Northwell.edu/FeinsteinGAPpledge
9. Financial Well-Being Action
10. Stress Reduction Action

Note: In order to make Wellness Actions, you must be enrolled in a medical plan.

Wellness

Northwell Health is committed to transforming care not only for patients but employees as well. The Health System offers many wellness resources and programs to help you improve your health.

Smoking Cessation/Center for Tobacco Control

The Health System's renowned Center for Tobacco Control (CTC) provides state-of-the-art tobacco prevention education, cessation services and clinical research. As an employee, you are eligible for free, customized programs to help you quit smoking. Contact: 516-466-1980 for more information.

Stress Management/Employee Assistance Program

In addition to offering stress management, the Employee Assistance Program (EAP) provides free, confidential counseling services. Qualified professional counselors are available to counsel you on a wide range of issues such as career conflicts, stress, depression, substance Use, marital problems, grief and many other issues. Schedule a confidential appointment: 1-877-327-4968.

Flu Vaccination, Immunizations and more/Employee Health Services

Employee Health Services (EHS) is Northwell Health's on-site medical provider for employees, administering a free flu vaccination and other immunizations. Contact your local EHS office or call the corporate center to schedule an appointment: 718-470-7644.

EXCLUSIONS: WHAT THE VALUE AND BUY-UP MEDICAL PLANS WILL NOT COVER OUTSIDE OF NORTHWELL HEALTH

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in *Additional Coverage Details Under the Value and Buy-Up Plans*.

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The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in, *Additional Coverage Details Under the Value and Buy-Up Plans*, those limits are stated in the corresponding Covered Health Service category in *Value and Buy-Up Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in *Value and Buy-Up Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Alternative Treatments

1. acupressure;
2. aromatherapy;
3. hypnotism;
4. massage therapy;
5. Rolfing (holistic tissue massage); and
6. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Additional Coverage Details Under the Value and Buy-Up Plans*.

Birth controls

Not covered for women over age 50.

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in, *Additional Coverage Details Under the Value and Buy-Up Plans*;

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

- extractions (including wisdom teeth);
- restoration and replacement of teeth;
- medical or surgical treatments of dental conditions; and
- services to improve dental clinical outcomes;

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Additional Coverage Details Under the Value and Buy-Up Plans*.

3. dental implants, bone grafts, and other implant-related procedures;

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services – Accident Only* in *Additional Coverage Details Under the Value and Buy-Up Plans*.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in *Additional Coverage Details Under the Value and Buy-Up Plans*.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;
2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in, *Additional Coverage Details Under the Value and Buy-Up Plans*: Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter. This exclusion does not include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.
3. cranial banding (except when prescribed by a physician);
4. the following items are excluded, even if prescribed by a Physician:
 - blood pressure cuff/monitor;

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- enuresis alarm;
 - non-wearable external defibrillator;
 - trusses;
 - ultrasonic nebulizers;
5. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;
 6. the replacement of lost or stolen prosthetic devices;
 7. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment in Additional Coverage Details Under the Value and Buy-Up Plans*;
 8. oral appliances for snoring.

Drugs

1. prescription drugs for outpatient use that are filled by a prescription order or refill
2. self-injectable medications. (This exclusion does not apply to medications which, due to their characteristics, as determined by UnitedHealthcare, must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting);
3. growth hormone therapy;
4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and
5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in *Glossary*.

This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services in Additional Coverage Details Under the Value and Buy-Up Plans*. Routine foot care services that are not covered include:

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- cutting or removal of corns and calluses;
- nail trimming or cutting; and
- debridement (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

- cleaning and soaking the feet;
- applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;
4. treatment of subluxation of the foot;
5. shoe inserts;
6. arch supports;
7. shoes (standard or custom), lifts and wedges; and
8. shoe orthotics.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical and disposable supplies. Examples of supplies that are not covered include, but are not limited to:

- ace bandages, diabetic strips, and syringes.

This exclusion does not apply to:

- ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in *Additional Coverage Details Under the Value and Buy-Up Plans*.
- disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in *Additional Coverage Details Under the Value and Buy-Up Plans*; or
- diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Additional Coverage Details Under the Value and Buy-Up Plans*.
- all catheters and dressings.

2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;

3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;
4. the replacement of lost or stolen Durable Medical Equipment; and
5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under Ostomy Supplies in *Additional Coverage Details Under the Value and Buy-Up Plans*.

Mental Health and Substance Use Disorder

In addition to all other exclusions listed in this *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorder - Autism Spectrum Disorder Services* and/or *Substance Use Disorder Services* in *Additional Coverage Details Under the Value and Buy-Up Plans*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* not classified as mental health or not classified at all.
2. Services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Experimental services (not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome).
 - Not clinically appropriate for the patient's Mental Illness, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks.
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.

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7. Learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
8. Intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
9. Mental Health Services as a treatment for non-mental health conditions
10. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
11. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction.
12. Any treatments or other specialized services designed for Autism Spectrum Disorder that are considered Experimental or Investigational or Unproven Services.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;
2. food of any kind. Foods that are not covered include:
 - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, unless they are the only source of nutrition or unless they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
 - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
 - oral vitamins and minerals;
 - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
 - other dietary and electrolyte supplements; and
3. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;
2. telephone;
3. beauty/barber service;

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4. guest service;
5. supplies, equipment and similar incidentals for personal comfort. Examples include:
 - air conditioners;
 - air purifiers and filters;
 - batteries and battery chargers;
 - dehumidifiers and humidifiers;
 - ergonomically correct chairs;
 - non-Hospital beds, comfort beds, motorized beds and mattresses;
 - breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
 - car seats;
 - chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
 - electric scooters;
 - exercise equipment and treadmills;
 - hot tubs, Jacuzzis, saunas and whirlpools;
 - medical alert systems;
 - music devices;
 - personal computers;
 - pillows;
 - power-operated vehicles;
 - radios;
 - strollers;
 - safety equipment;
 - vehicle modifications such as van lifts;
 - video players; and
 - home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in *Glossary*, are excluded from coverage. Examples include:
 - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
 - pharmacological regimens;
 - nutritional procedures or treatments;
 - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
 - hair removal or replacement by any means;
 - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
 - treatment for spider veins;
 - skin abrasion procedures performed as a treatment for acne;
 - treatments for hair loss;
 - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
 - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure; Cosmetic procedures or any complications unless life threatening resulting from cosmetic procedures are excluded.
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;
3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;
4. wigs regardless of the reason for the hair loss except for temporary loss of hair resulting from treatment of a malignancy; and
5. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;
2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);
3. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;

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4. speech therapy to treat stuttering, stammering, or other articulation disorders;
5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in *Additional Coverage Details*;
6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;
7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);
8. psychosurgery (lobotomy);
9. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;
10. chelation therapy, except to treat heavy metal poisoning;
11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies is covered only by using a top tier provider.
12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;
13. the following treatments for obesity:
 - non-surgical treatment, even if for morbid obesity; and
 - surgical treatment of obesity unless there is a diagnosis of morbid obesity as described under *Obesity Surgery* *Additional Coverage Details*;
14. breast reduction surgery that is determined to be a Cosmetic Procedure.

This exclusion does not apply to breast reduction surgery which the Claims Administrator determines is requested to treat a physiologic functional impairment or to coverage required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child or any provider that is owned by or under the control of such a family member;
2. a provider may perform on himself or herself;
3. performed by a provider with your same legal residence;
4. ordered or delivered by a Christian Science practitioner;
5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;
6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;
7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and
8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:
 - prior to ordering the service; or
 - after the service is received.

This exclusion does not apply to mammography testing.

9. for which the recipient has no legal obligation to pay or which no charge or attempt to collect would be made in the absence of coverage under the Plan
10. for which an employee cost sharing amount is payable under the Plan and payment which cost sharing amount is waived ,or not attempted to be collected by, the provider of the services.

Reproduction

1. the following infertility treatment-related services:
 - cryo-preservation and other forms of preservation of reproductive materials;
 - long-term storage of reproductive materials such as sperm, eggs, embryos, ovarian tissue, and testicular tissue; and
 - donor services;
2. in vitro fertilization regardless of the reason for treatment;

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3. surrogate parenting, donor eggs, donor sperm and host uterus;
4. the reversal of voluntary sterilization;
5. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
6. services provided by a doula (labor aide); and
7. parenting, pre-natal or birthing classes.

Services Provided OR COVERED under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in *Coordination of Benefits (COB)*;
2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services in Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and
3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and
2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging in Additional Coverage Details*. Additional travel expenses related to Covered Health Services received from a Designated Facility or

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Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Additional Coverage Details*.

1. Cryopreservation of fertilized embryos.
2. Voice modification surgery.

Types of Care

1. Custodial Care as defined in *Glossary* or maintenance care;
2. Domiciliary Care, as defined in *Glossary*;
3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;
4. Private Duty Nursing;
5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Additional Coverage Details*;
6. rest cures;
7. services of personal care attendants;
8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. routine vision examinations, including refractive examinations to determine the need for vision correction;
2. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);
3. purchase cost and associated fitting charges for eyeglasses or contact lenses;
4. eye exercise or vision therapy; and
5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;
2. charges for:
 - missed appointments;
 - room or facility reservations;
 - completion of claim forms; or
 - record processing.
3. charges prohibited by federal anti-kickback or self-referral statutes;
4. diagnostic tests that are:
 - delivered in other than a Physician's office or health care facility; and
 - self-administered home diagnostic tests,;
5. expenses for health services and supplies:
 - that do not meet the definition of a Covered Health Service in *Glossary*;
 - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
 - that are received before the date your coverage under this Plan begins or after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
 - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
 - that exceed Eligible Expenses or any specified limitation in this SPD;
 - for which a Network or non-Network provider waives the Copay, Annual Deductible or Coinsurance amounts;
6. foreign language and sign language services;
7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;
8. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
 - required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
 - conducted for purposes of medical research.
 - related to judicial or administrative proceedings or orders; or
 - required to obtain or maintain a license of any type.

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COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by Value or Buy-up plan, and other health benefits plan(s), including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional “fault” type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit
-

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com or call 1-888-254-3698 to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;

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- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;
- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - the parents are married or living together whether or not they have ever been married and not legally separated; or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - the parent with custody of the child; then
 - the Spouse of the parent with custody of the child; then
 - the parent not having custody of the child; then
 - the Spouse of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; Only expenses normally paid by the Plan will be paid under COB; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.

2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

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When This Plan is Secondary

If this Plan is secondary to any plan other than Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the allowable expense.
- if this Plan would have paid less than the primary plan paid, the Plan pays no Benefits.
- if this Plan would have paid more than the primary plan paid, the Plan will pay the difference.

You will be responsible for any Copay, Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you can receive from all plans may be less than 100% of the total allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary, the allowable expense is the primary plan's In-Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a In-Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a Non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a Non-Network provider for the primary plan and a In-Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a Non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare***Determining Which Plan is Primary***

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older; and

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- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

If This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid had it been the only plan involved.
- the Plan pays the entire difference between the allowable expense and the amount paid by the primary plan - as long as this amount is not more than the Plan would have paid had it been the only plan involved.
- if the Plan would have paid more if it were the only plan involved, the difference between the amount it would have paid and the amount it actually paid is recorded as a benefit reserve for the Covered Person. This reserve can be used to pay any future allowable expenses not otherwise paid by the Plan during the calendar year.
- at the end of the calendar year, the benefit reserve returns to zero. A new benefit reserve is created for each calendar year.

The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Medicare Cross-Over Program

The Plan offers a Medicare Cross-over Program for Medicare Part A claims. If you enroll for this program, you no longer have to file a separate claim with the Plan to receive secondary benefits for these expenses.

Once the Medicare Part A carrier[s] have reimbursed your health care provider, the Medicare carrier will electronically submit the necessary information to the Claims Administrator to process the balance of your claim under the provisions of this Plan.

To participate in the Medicare Cross-over Program, you must complete a special form authorizing this service and submit it to the Claims Administrator. Your Spouse also can

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enroll for this program, as long as he or she is eligible for Medicare and this Plan is your only secondary medical coverage.

You can verify that the automated cross-over is in place when your copy of the explanation of Medicare benefits (EOMB) states your claim has been forwarded to your secondary carrier. Until this message appears, you must continue to file secondary claims with the Claims Administrator.

This cross-over process does not apply to expenses under Part B (Physician office visits) and DME Medicare expenses or expenses that Medicare does not cover. You must continue to file claims for these expenses.

For information about enrollment or if you have questions about the program, call 1-888-254-3698.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans.

UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that the Claims Administrator should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Plan Sponsor may recover the amount in the form of salary, wages, or benefits payable under any Plan Sponsor benefit plans, including this Plan. The Plan Sponsor also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, the Claims Administrator reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

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Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- The Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment the Plan made exceeded the Benefits under the Plan.
- All or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which the Claims Administrator makes payments, with the understanding that the Claims Administrator will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

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SUBROGATION AND REIMBURSEMENT**What this section includes:**

- How your Benefits are impacted if you suffer a Sickness or Injury caused by a third party.

The Plan has a right to subrogation and reimbursement, as explained below.

Right of Recovery

The Plan has the right to recover benefits it has paid on your or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or
- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

Right to Subrogation

The right to subrogation means the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is considered, or is alleged to be, responsible. Subrogation applies when the Plan has paid

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on your behalf Benefits for a Sickness or Injury for which a third party is considered, or is alleged to be, responsible, e.g. an insurance carrier if you are involved in an auto accident.

The Plan shall be subrogated to, and shall succeed to, all rights of recovery from any or all third parties, under any legal theory of any type, for 100 percent of any services and Benefits the Plan has paid on your behalf relating to any Sickness or Injury caused by any third party.

Right to Reimbursement From a Recovery

The right to reimbursement ("Reimbursement") means that if a third party causes, or is alleged to have caused, a Sickness or Injury for which you receive a Recovery from any third party, you must fully return to the Plan from that Recovery 100% of any Benefits you received for that Sickness or Injury. "Recovery" means the specific fund of any and all monies paid to you by judgment, settlement, arbitration or otherwise (no matter how those monies may be allocated, characterized or designated) to compensate you for any losses caused by, or in connection with, that Sickness or Injury. Any Recovery shall apply first to Reimbursement, regardless of whether you are made whole by the Recovery.

Third Parties

The following persons and entities are considered third parties:

- a person or entity which caused, or is alleged to have caused, you to suffer a Sickness, Injury or damages, or who is legally responsible or alleged to be legally responsible, for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- Northwell Health in workers' compensation cases; or
- any person or entity who is or may be obligated to provide you with benefits or payments under:
 - underinsured or uninsured motorist insurance;
 - medical provisions of no-fault or traditional insurance (auto, homeowners or otherwise);
 - workers' compensation coverage; or
 - any other insurance carrier or third party administrator.

Subrogation and Reimbursement Provisions

As a Covered Person, you agree to the following:

- the Plan has a first priority right to receive Reimbursement from any Recovery before you receive payment from that third party and that right supersedes any right

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you have to be made whole. In other words the Plan's right to be Reimbursed from the Recovery applies first, regardless of whether you receive compensation from the Recovery for any damages or expenses, and the Plan's right of Reimbursement will not be reduced by any attorneys' fees or other costs incurred by you. Further, the Plan's first priority right to payment from the Recovery is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds you recover from a third party.

- the Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries, or pay any of your associated costs, including attorneys' fees. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" or "Make Whole Rule" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from the Recovery the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- you will cooperate with the Plan and its agents in a timely manner to protect its legal and equitable rights to subrogation and Reimbursement from the Recovery, including:
 - complying with the terms of this section;
 - providing any relevant information requested;
 - signing and/or delivering documents at its request;
 - notifying the plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
 - responding to requests for information about any accident or injuries;
 - appearing at medical examinations and legal proceedings, such as depositions or hearings; and
 - obtaining the Plan's consent before releasing any party from liability or payment of medical expenses.
- if you receive a Recovery from any third party as a result of a Sickness or Injury, and the Plan alleges some or all of the Recovery is due and owed to it, you agree to hold those the Recovery in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over the Recovery to the extent of the Benefits the Plan has paid.

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- if the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from the Recovery
- you may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of Benefits the Plan has provided for a Sickness or Injury caused by a third party.
- the Plan's rights will not be reduced due to your own negligence.
- the Plan may, at its option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain.
- the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- in case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- your failure to cooperate with the Plan or its agents is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan.
- if a third party causes you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer a Covered Person.
- the Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive services under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

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OTHER IMPORTANT INFORMATION**What this section includes:**

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and Northwell Health;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Spousal Surcharge

If your spouse is eligible for coverage through his/her own employer and you choose to cover him/her under the Plan's medical benefit, you will be subject to an annual surcharge of \$1,140 in addition to any other contributions due from you. This amount is subject to change in future years.

Northwell Health Married Employees' Election

If you are married to another Northwell Health employee who is also eligible for benefits under the Plan, and you are not in the same benefit group the following will apply: the employee in the lower benefit group can be covered under the benefits of the spouse in the higher benefit group. However, the employee in the higher benefit group cannot be covered under the employee in the lower benefit group. See below for the list of defined benefit groups:

- **Benefit Group 3** generally refers to staff-level employees
- **Benefit Group 2** generally refers to manager-level employees and clinical mid-level providers
- **Benefit Groups 1** generally refers to directors and AVPs
- **Benefit Group 1A** refers to executives (above the AVP level) and physicians
 - Benefit Group 1A is considered the "highest benefit group"

For more about these changes visit: nsljbenefits.blogspot.com

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

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If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Northwell Health

In order to make choices about your health care coverage and treatment, Northwell Health believes that it is important for you to understand how UnitedHealthcare interacts with the Plan and how it may affect you. UnitedHealthcare helps administer the Plan. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- Your Employer and UnitedHealthcare do not decide what care you need or will receive. You and your Physician make those decisions;
- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost. And you are always responsible for your applicable cost sharing, such as deductibles, copays and coinsurance.

Northwell Health and UnitedHealthcare may use individually identifiable information about you to identify for you procedures, products or services that you may find valuable. Northwell Health and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Northwell Health and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Medical Providers

The relationships between Northwell Health, UnitedHealthcare and Non- Northwell Health In-System In-Network providers are solely contractual relationships. Non-Northwell Health In-System In-Network providers are not Northwell Health System's agents or employees, nor are they agents or employees of UnitedHealthcare. Northwell Health and any of its employees are not agents or employees of In-Network providers, nor are UnitedHealthcare and any of its employees' agents or employees of In-Network providers.

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UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan. The Plan Administrator is Northwell Health.

The Plan Administrator is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage); and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Medical Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;
- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

The Plan Sponsor and Plan Administrator has the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; make factual determinations related to the Plan and its Benefits, including, but not limited to, whether Benefits are payable under the Plan and if so, to what extent; and
- make any other determinations related to the administration and operation of the Plan.

The Plan Sponsor and Plan Administrator may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan, including the Claims Administrators.

Without limiting the above, the Plan Sponsor and Plan Administrator has delegated to the Claims Administrators the discretion and authority to decide whether, or to what extent, a treatment or supply is covered and how the eligible expenses will be

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determined and otherwise covered under the Plan, what Benefits are payable, and how appeals of denied claims will be decided. Northwell Health, in its sole discretion, approves exception procedures.

All interpretations and determinations made by the Plan Sponsor, a Claims Administrator, or either of their delegates are final and binding unless determined by clear and convincing evidence to be arbitrary and capricious by a court of competent jurisdiction.

In certain circumstances, for purposes of overall cost savings or efficiency the Plan Sponsor and Plan Administrator may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that the Plan Sponsor and Plan Administrator does so in any particular case shall not in any way be deemed to require the Plan Sponsor and Plan Administrator to do so in other similar cases.

Information and Records

Northwell Health and UnitedHealthcare may without your authorization use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Northwell Health and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Northwell Health and UnitedHealthcare will keep this information confidential. Northwell Health and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By being covered under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Northwell Health and UnitedHealthcare with all information or copies of records relating to the services provided to you. Northwell Health and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. Northwell Health and UnitedHealthcare agree that such information and records will be considered confidential in accordance with applicable law.

Northwell Health and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment (including, but not limited to, review or assessment by CareSolutions or any successor) or as Northwell Health is required to do by law or regulation. During and after the term of the Plan, Northwell Health and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

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For complete listings of your medical records or billing statements Northwell Health recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Northwell Health and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

In-Network providers may be provided financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for In-Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of In-Network providers receives a monthly payment for each Covered Person who selects a In-Network provider within the group to perform or coordinate certain health services. The In-Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.
- If you have any questions regarding financial incentives you may call 1-888-254- 3698. You can ask whether your In-Network provider is paid by any financial incentive, including those listed above. In addition, you may choose to discuss these financial incentives with your In-Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but the Health System recommends that you discuss participating in such programs with your Physician. . You may call 1-888-254-3698 if you have any questions.

Rebates and Other Payments

Northwell Health and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your

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Annual Deductible. Northwell Health and UnitedHealthcare do not pass these rebates on to you as the rebates belong solely to Northwell Health and UnitedHealthcare nor are they applied to your Employee contributions, your Annual Deductible or taken into account in determining your Copays or Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan-No Vesting

Although the Plan Sponsor expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time, at its sole determination. Such discontinuation, alteration or modification shall be by a written instrument signed or approved a duly-authorized officer of the Plan Sponsor, Northwell Health. There are no vested rights, Benefits or coverages under the Plan.

This Plan Document

A copy of this Summary Plan Description/Plan Document is available on the employee intranet in the office of the Plan Administrator during regular business hours. You (or your personal representative) may obtain a copy of this document free of charge by written request to the Plan Administrator.

CLAIMS/APPEALS

If you wish to make a claim for any benefits under any of the Northwell Health System Flex Benefit Program, please file your claim with the Claims Administrator for the benefit to which your claim relates. The contact information for each of the Claims Administrators is below. If, however, your claim relates to whether or not you are a benefit-eligible employee or dependent, your claim should be filed with the Plan Administrator, which has full discretionary authority to decide that that claim and any appeal thereof.

Part I of this Claims/Appeals section contains general information applicable to all benefits under the Plan, such as the Claims Administrators' contact information, the information you will receive in any denial notices, and a description of the external review process for medical benefits. Any procedures that are specific to specific benefit coverages are described in Part II of this Claims/Appeals section. Please also refer to the insurance certificates (which will control in the event of any conflict with this section) if your claim or appeal pertains to a fully-insured benefit.

PART II: CLAIM AND APPEAL INFORMATION FOR SPECIFIC BENEFITS

This Part II contains procedures provided by the Claims Administrators for their benefit coverages.

UNITEDHEALTHCARE CLAIMS PROCEDURES FOR THE VALUE AND BUY-UP MEDICAL OPTIONS**In-System Benefits**

In general, if you receive Covered Health Services from an In-System provider, UnitedHealthcare will pay the Physician or facility directly. If an In-System provider bills you for any Covered Health Service other than your Copay, please contact the provider or call UnitedHealthcare at 1-888-254-3698 for assistance.

In-Network Benefits

In general, if you receive Covered Health Services from an In-Network provider, UnitedHealthcare will pay the Physician or facility directly. If an In-Network provider bills you for any Covered Health Service other than your Copay or Coinsurance, please contact the provider or call UnitedHealthcare at 1-888-254-3698 for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to an In-Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a Non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at:

UnitedHealthcare Medical Claims:
PO Box 740800
Atlanta, GA 30374-0800

How to File a Claim

You can obtain a claim form by visiting **www.myuhc.com**, calling 1-888-254-3698 or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- your name and address;
- the patient's name, age and relationship to the Participant;
- the number as shown on your ID card;
- the name, address and tax identification number of the provider of the service(s);
- a diagnosis from the Physician;
- the date of service;
- an itemized bill from the provider that includes:
 - the Current Procedural Terminology (CPT) codes;
 - a description of, and the charge for, each service;
 - the date the Sickness or Injury began; and
 - a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may result in a denial or delay any reimbursement that may be due you.

The above information should be filed with UnitedHealthcare at:

UnitedHealthcare Medical Claims:
PO Box 740800
Atlanta, GA 30374-0800

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the Non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

No Assignment or Alienation

No amount payable at any time as a benefit under any Benefit, nor any right you may have to file a lawsuit on any grounds whatsoever (including, but not limited to an alleged failure to pay a benefit due or alleged breach of fiduciary duty or alleged failure to produce requested documents) against the Plan the Plan Sponsor, an Employer or any officer, shareholder or employee thereof; the Plan Administrator; a Claims Administrator; or any other Plan fiduciary, shall be subject in any manner to alienation, anticipation, sale, transfer, assignment, bankruptcy, garnishment, pledge, attachment, charge or encumbrance of any kind. Any action in violation of this provision shall be void. If you become bankrupt or attempts to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount payable under the Plan, or if any Plan benefit be garnished, attached or levied upon, the Claims Administrator, if it so elects, may direct that such amount be withheld and that the same amount or any part thereof be paid or applied to or for the benefit of such person, in such manner and proportion as the Claims Administrator may deem proper.

Notwithstanding the foregoing, you may request that, in the discretion of the Claims Administrator, a reimbursement for a benefit that is covered under the Plan that you have a right to receive, instead be paid to a qualified healthcare provider who has provided the services for which such reimbursement is claimed. Where benefits are paid directly to a doctor, hospital or other provider of care, such direct payments are provided in the discretion of the Claims Administrator as a convenience to you and are not an enforceable assignment of Plan benefits or the right to receive or assign such benefits. If the Plan pays a Non-Network provider directly for services rendered to you, the Plan reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes the Plan.

Health Statements

Each month, in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at **www.myuhc.com**. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You can sign up for electronic EOBs, or may also request to receive a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call 1-888-254-3698 to request them. You can also view and print all of your EOBs online at www.myuhc.com. See *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Claims

All claim forms must be submitted within 90 days after the date of service for In-Network claims and 12 months after the date of service for Out-of-Network claims. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are determined by UnitedHealthcare to be legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals***If Your Claim is Denied***

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at 1-888-254-3698 before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, Utah 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at 1-888-254-3698 to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination. UnitedHealthcare must notify you of the appeal determination within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

External Review Program

If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the external review program. This program only applies if the adverse benefit determination is based on:

-
- clinical reasons;
 - the exclusions for Experimental or Investigational Services or Unproven Services; or
 - as otherwise required by applicable law.

This external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above and you receive a decision that is unfavorable, or if UnitedHealthcare fails to respond to your appeal within the time lines stated below.

You may request an independent review of the adverse benefit determination. Neither you nor UnitedHealthcare will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. You, your treating Physician or an authorized designated representative may request an independent review by calling 1-888-254-3698 or by sending a written request to:

UnitedHealthcare Medical Claims:
PO Box 740800
Atlanta, GA 30374-0800

The independent review will be performed by an independent Physician, or by a Physician who is qualified to decide whether the requested service or procedure is a Covered Health Service under the Plan. The Independent Review Organization (IRO) has been contracted by UnitedHealthcare and has no material affiliation or interest with UnitedHealthcare. UnitedHealthcare will choose the IRO based on a rotating list of approved IROs.

In certain cases, the independent review may be performed by a panel of Physicians, as deemed appropriate by the IRO.

Within applicable timeframes of UnitedHealthcare's receipt of a request for independent review, the request will be forwarded to the IRO, together with:

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare in making a decision on the case; and
- all other information or evidence that you or your Physician has already submitted to UnitedHealthcare.

If there is any information or evidence you or your Physician wish to submit in support of the request that was not previously provided, you may include this information with

the request for an independent review, and UnitedHealthcare will include it with the documents forwarded to the IRO. A decision will be made within applicable timeframes. If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and UnitedHealthcare with the reviewer's decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide Benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the service or procedure.

You may contact UnitedHealthcare at 1-888-254-3698 for more information regarding your external appeal rights and the independent review process.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must notify UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	24 hours
You must then provide completed request for Benefits to UnitedHealthcare within:	48 hours after receiving notice of

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
	additional information required
UnitedHealthcare must notify you of the benefit determination within:	72 hours
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	5 days
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	15 days
You must then provide completed request for Benefits information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
<ul style="list-style-type: none"> if the initial request for Benefits is complete, within: 	15 days
<ul style="list-style-type: none"> after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within: 	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	15 days after receiving the first level appeal

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	Timing
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	15 days after receiving the second level appeal*

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
<ul style="list-style-type: none"> if the initial claim is complete, within: 	30 days
<ul style="list-style-type: none"> after receiving the completed claim (if the initial claim is incomplete), within: 	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	30 days after receiving the second level appeal*

*UnitedHealthcare may be entitled to a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

See “Exhaustion of Remedies; Limitation Period; Venue” under Part I of this Section *Claims /Appeals* for information on your right to bring a lawsuit against the Plan.

External Appeals Review

You can request an external review by an Independent Review Organization (IRO) as an additional level of appeal prior to, or instead of filing a civil action with respect to your claim under Section 502(a) of ERISA. Generally, to be eligible for an independent external review, you must exhaust the internal plan claim review process described above, unless your claim and appeals were not reviewed in accordance with all of the legal requirements relating to pharmacy benefit claims and appeals or your appeal is urgent. In the case of an urgent appeal, you can submit your appeal to both the plan and request an external independent review at the same time, or alternatively you can submit your urgent appeal for the external independent review after you have completed the internal appeal process.

To file for an independent external review, Express Scripts-Medco must receive your external review request within 4 months of the date of the adverse benefit determination (If the date that is 4 months from that date is a Saturday, Sunday or holiday, the deadline is the next business day) at: Express Scripts / Medco Health Solutions Attn: External Review Requests P.O. Box 631850 Irving TX 75063-0030. Phone: 1-800-753-2851 Fax: 1-888-235-8551

Non-Urgent External Review

Once you have submitted your external review request, your claim will be reviewed within 5 business days to determine if you are eligible for external review, and within 1 business day of the IRO’s decision, send you a letter notifying you whether your request has been approved for external review.

If you are eligible for an external review, the Plan will randomly assign the review request to an IRO and compile your appeal information and send it to the IRO within 5 business days. The IRO will notify you in writing that it has received the request for an external review. The letter will describe your right to submit additional information for consideration to the IRO. Any additional information you submit to the IRO will also be sent back to the Plan for reconsideration. The IRO will review your claim within 45 calendar days and send written notice of its decision.

WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- How to continue coverage after it ends; and
- Conversion of coverage.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, the Plan will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended.

End of Medical (including Prescription Drug), Dental, Vision, Health Care Flexible Spending Account and Dependent Care Flexible Spending Account Coverages

Your medical, dental, vision, and Health and Dependent Care FSA coverages under the Plan will end on the earliest of:

- the last day of the month your employment with the Health System ends;
- the date the Plan ends;
- the last day of the month you stop making the required contributions;
- the last day of the month you are no longer eligible; or
- the date selected by Northwell Health, in its discretion.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the last day of the month you stop making the required contributions;
- the last day of the month your Dependents no longer qualify as Dependents under this Plan; or
- the date selected by Northwell Health, in its discretion.

Conversion of Coverage

Unless an SPD provides otherwise, the Plan will not furnish conversion of coverage; provided that you will not be precluded from exercising any conversion option made available to you by an insurance carrier under the Plan. Unless an SPD provides otherwise, neither the Plan Administrator, the Health System, nor any employer will have any obligation to provide notice of any such conversion option.

Additional Coverage Options

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

EXHIBIT C

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Certificate of Coverage

For

the Plan AGZ3

of

TriStar Global Energy Solutions, Inc.

Enrolling Group Number: 907924

Effective Date: April 1, 2018

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-0450

860-702-5000

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call UnitedHealthcare Insurance Company's toll-free telephone number for information or to make a complaint at:

Austin **1-800-424-6480**

Dallas **1-800-458-5653**

Houston **1-800-548-1078**

San Antonio **1-800-842-0174**

You may also write to UnitedHealthcare Insurance Company at:

185 Asylum Street

Hartford Connecticut 06013-3408

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may also write the Texas Department of Insurance:

P.O. Box 149104

Austin, TX 78714-9104

Fax: (512) 490-1007

Web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov.

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

AVISO IMPORTANTE

Para obtener informacion o para presentar una queja:

Usted puede llamar al numero de telefono gratuito de UnitedHealthcare Insurance Company's para obtener informacion o para presentar una queja al:

Austin **1-800-424-6480**

Dallas **1-800-458-5653**

Houston **1-800-548-1078**

San Antonio **1-800-842-0174**

Usted tambien puede escribir a UnitedHealthcare Insurance Company:

185 Asylum Street

Hartford Connecticut 06013-3408

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener informacion sobre companias, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104

Austin, TX 78714-9104

Fax: (512) 490-1007

Sitio web: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov.

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES:

Si tiene una disputa relacionada con su prima de seguro o con una reclamacion, usted debe comunicarse con la Compania primero. Si la disputa no es resuelta, usted puede comunicarse con el

Departamento de Seguros de Texas.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

ADJUNTE ESTE AVISO A SU POLIZA:

Este aviso es solamente para propositos informativos y no se convierte en parte o en condicion del documento adjunto.

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UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

You can choose to receive Designated Network Benefits, Network Benefits or Non-Network Benefits.

Designated Network Benefits apply to Covered Health Services that are provided by a Network Physician or other provider that we have identified as a Designated Facility or Physician. Designated Network Benefits are available only for specific Covered Health Services as identified in the *Schedule of Benefits* table below.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. You are not required to select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*.

Covered Health Services that are provided at a Network facility by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as *Out-of-Network Benefits*.

If an amount you owe to a non-Network hospital-based Physician for services received in a Network hospital is over \$500, the claim is eligible for mediation of any unpaid amount (not including any applicable copayment, deductible and coinsurance) under Texas Insurance Code Chapter 1467 and Chapter 21. Please note that we will not require that you participate in a mediation and we will not penalize you if do not request mediation. After we request that you initiate mediation we are not responsible for any balance bill that you may receive from a provider, until you request mediation. The hospital-based Physician cannot continue to bill you for any amounts other than, copayments, deductibles and coinsurance until the mediation is completed or withdrawn. If the amount of a claim is changed as a result of mediation, we will adjust the amount of payment based on the results of the mediation.

Please refer to www.tdi.texas.gov/consumer/cpmmediation.html. for instructions on how to request mediation.

Depending on the geographic area and the service you receive, you may have access to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you

are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Enrolling Group, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which you are required to obtain prior authorization are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to determine how far in advance you must obtain prior authorization.

- Acquired Brain Injury.
- Ambulance - non-emergent air and ground.
- Amino Acid-Based Elemental Formulas.
- Autism Spectrum Disorders.
- Breast pumps.
- Clinical trials.
- Congenital heart disease surgery.

- Dental services - accidental.
- Developmental Delay.
- Durable Medical Equipment over \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).
- Formulas/specialized foods.
- Genetic Testing - BRCA.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
- Lab, X-ray and diagnostics - sleep studies, stress echocardiography and transthoracic echocardiogram.
- Lab, X-ray and major diagnostics - CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology.
- Mental Health Services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electroconvulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including *Applied Behavioral Analysis (ABA)*.
- Orthotic Devices and Prosthetic Devices for Artificial Arms and Legs.
- Pain management.
- Prosthetic devices over \$1,000 in cost per device.
- Reconstructive procedures, including breast reconstruction surgery following mastectomy.
- Rehabilitation services and Manipulative Treatment - physical therapy, occupational therapy, Manipulative Treatment and speech therapy.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including services at a Residential Treatment facility); Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder.
- Surgery - only for the following outpatient surgeries: cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgeries.
- Temporomandibular joint services.

- Therapeutics - only for the following services: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound.
- Transplants.

For all other services, when you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

When Benefit limits apply, the limit stated refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
<p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>When a Covered Person was previously covered under a</p>	<p>Designated Network and Network</p> <p>\$2,500 per Covered Person, not to exceed \$5,000 for all Covered Persons in a family.</p> <p>Non-Network</p> <p>\$5,000 per Covered Person, not to exceed \$10,000 for all Covered</p>

Payment Term And Description	Amounts
<p>group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	<p>Persons in a family.</p>
<p>Out-of-Pocket Maximum</p> <p>The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i>. The Out-of-Pocket Maximum for Designated Network and Network Benefits includes the amount you pay for both Network and Non-Network Benefits for outpatient prescription drug products provided under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> Any charges for non-Covered Health Services. The amount Benefits are reduced if you do not obtain prior authorization as required. Charges that exceed Eligible Expenses. Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum. 	<p>Designated Network and Network</p> <p>\$6,000 per Covered Person, not to exceed \$12,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Maximum includes the Annual Deductible.</p> <p>Non-Network</p> <p>\$10,000 per Covered Person, not to exceed \$20,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Maximum includes the Annual Deductible.</p>
<p>Copayment</p>	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> The applicable Copayment. 	

Payment Term And Description	Amounts
<ul style="list-style-type: none"> The Eligible Expense. <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
Coinsurance	
<p>Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. Ambulance Services			
<p>Prior Authorization Requirement</p> <p>In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.</p>			
Emergency Ambulance	Network <i>Ground Ambulance:</i> 80% <i>Air Ambulance:</i> 80% Non-Network Same as Network	Yes Yes Same as Network	Yes Yes Same as Network
Non-Emergency Ambulance Ground or air ambulance, as appropriate.	Network <i>Ground Ambulance:</i> 80% <i>Air Ambulance:</i> 80% Non-Network <i>Ground Ambulance:</i> 50% <i>Air Ambulance:</i> 50%	Yes Yes Yes Yes	Yes Yes Yes Yes
2. Clinical Trials			
<p>Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.</p>			
Depending upon the Covered Health Service. Benefit limits are the same	Network		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> . Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
3. Congenital Heart Disease Surgeries			
Prior Authorization Requirement			
For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
4. Dental Services - Accident Only			
Prior Authorization Requirement			
For Network and Non-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, Benefits will be			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
	Network 80% Non-Network Same as Network	Yes Same as Network	Yes Same as Network
5. Diabetes Services			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Non-Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
Diabetes Self-Management Items	Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i> .		
Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not subject to the limit stated under <i>Durable Medical Equipment</i> . Benefits for podiatric appliances are limited to two pairs of therapeutic footwear per year for the prevention of complications associated with			

<i>When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.</i>			
Covered Health Service	Benefit <i>(The Amount We Pay, based on Eligible Expenses)</i>	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
diabetes.	<i>Non-Network</i> Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i> .		
6. Durable Medical Equipment			
<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.</p>			
Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years. This limit does not apply to wound vacuums, which are limited to a single purchase (including repair/replacement) every three years. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	<i>Network</i> 80% <i>Non-Network</i> 50%	Yes Yes	Yes Yes
7. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission or as soon as reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to	<i>Network</i> 80% after you pay a Copayment of \$250 per visit. If you are admitted as an inpatient to a Network Hospital directly from the Emergency room you will not have to	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under <i>Eligible Expenses</i> in this <i>Schedule of Benefits</i> .	pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead. <		

<i>When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.</i>			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	50%	Yes	Yes
10. Hospice Care	<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.</p>		
	Network 80% Non-Network 50%	Yes Yes	Yes Yes
11. Hospital - Inpatient Stay	<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p>		
	Network 80% Non-Network 50%	Yes Yes	Yes Yes
12. Lab, X-Ray and Diagnostics - Outpatient	<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits for sleep studies, stress echocardiography and transthoracic echocardiogram, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.</p>		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Lab Testing - Outpatient	Network 100%	Yes	No
	Non-Network 50%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient	Network 100%	Yes	No
	Non-Network 50%	Yes	Yes
13. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
Prior Authorization Requirement For Non-Network Benefits for CT, PET scans, MRI, MRA, capsule endoscopy and nuclear medicine, including nuclear cardiology, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
14. Mental Health Services and Serious Mental Illness Services			
Prior Authorization Requirement For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; transcranial magnetic stimulation; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.			

<i>When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.</i>			
Covered Health Service	Benefit <i>(The Amount We Pay, based on Eligible Expenses)</i>	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
	<i>Network</i> <i>Inpatient</i> 80% <i>Outpatient</i> 100% after you pay a Copayment of \$30 per visit 80% for Partial Hospitalization/Intensive Outpatient Treatment <i>Non-Network</i> <i>Inpatient</i> 50% <i>Outpatient</i> 50% 50% for Partial Hospitalization/Intensive Outpatient Treatment	 Yes Yes Yes Yes Yes Yes Yes	 Yes No Yes Yes Yes Yes Yes
15. Neurobiological Disorders - Autism Spectrum Disorder Services			
<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Intensive Behavioral Therapy, including <i>Applied Behavioral Analysis (ABA)</i>.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible</p>			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Expenses, however the reduction in Benefits will not exceed \$500.			
	Network <i>Inpatient</i> 80% <i>Outpatient</i> 100% after you pay a Copayment of \$30 per visit 80% for Partial Hospitalization/Intensive Outpatient Treatment Non-Network <i>Inpatient</i> 50% <i>Outpatient</i> 50% 50% for Partial Hospitalization/Intensive Outpatient Treatment	Yes Yes Yes Yes Yes Yes Yes	Yes No Yes Yes Yes Yes
16. Ostomy Supplies			
	Network 80% Non-Network 50%	Yes Yes	Yes Yes
17. Pharmaceutical Products - Outpatient			
	Network 80% Non-Network 50%	Yes Yes	Yes Yes

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
18. Physician Fees for Surgical and Medical Services			
Covered Health Services provided by a non-Network facility based Physician in a Network facility will be paid at the Network Benefits level, however Eligible Expenses will be determined as described below under <i>Eligible Expenses</i> in this <i>Schedule of Benefits</i> . As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.	Designated Network		
	80% for Covered Health Services from a Primary Physician	Yes	Yes
	80% for Covered Health Services from a Specialist Physician	Yes	Yes
	Network		
	80% for Covered Health Services from a Primary Physician	Yes	Yes
	80% for Covered Health Services from a Specialist Physician	Yes	Yes
	Non-Network		
	50%	Yes	Yes
19. Physician's Office Services - Sickness and Injury			
Prior Authorization Requirement			
For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before Genetic Testing - BRCA is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
	Designated Network		
	For Covered Persons under the age of 19:		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>No deductible is applicable to necessary diagnostic follow-up care relating to the screening test for hearing loss of newborn Dependents from birth through 24 months.</p> <p>In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician's office:</p> <ul style="list-style-type: none"> Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>. Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>. Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and</i> 	<p>100% per visit for a Primary Physician office visit or \$60 per visit for a Specialist Physician office visit</p>	Yes	No
	<p>For Covered Persons age 19 and older:</p> <p>100% after you pay a Copayment of \$30 per visit for a Primary Physician office visit or \$30 per visit for a Specialist Physician office visit</p>	Yes	No
	<p>Network</p> <p>For Covered Persons under the age of 19:</p> <p>100% per visit for a Primary Physician office visit or \$60 per visit for a Specialist Physician office visit</p>	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p><i>Therapeutic.</i></p> <ul style="list-style-type: none"> • Outpatient surgery procedures described under <i>Surgery - Outpatient.</i> • Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i> 	<p>For Covered Persons age 19 and older:</p> <p>100% after you pay a Copayment of \$30 per visit for a Primary Physician office visit or \$60 per visit for a Specialist Physician office visit</p> <p>Non-Network</p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>Yes</p>
20. Pregnancy - Maternity Services			
<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.</p> <p>It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</p>			
	<p>Network</p> <p>Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> except</p>		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. Non-Network Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
21. Preventive Care Services			
Prior Authorization Requirement For Non-Network Benefits, you must obtain prior authorization before obtaining a breast pump. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
Physician office services	Network 100%	No	No
	Non-Network 50%		
Lab, X-ray or other preventive tests	Network 100%	No	No
	Non-Network 50%		
Breast pumps	Network 100%	No	No
	Non-Network 50%		
Childhood Immunizations	Network 100%	No	No
	Non-Network 100%		
		Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
22. Prosthetic Devices for other than Arms and Legs			
Prior Authorization Requirement			
For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed \$1,000 in cost per device. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
Benefits are limited to a single purchase of each type of prosthetic device every three years. Once this limit is reached, Benefits continue to be available for items required by the <i>Women's Health and Cancer Rights Act of 1998</i> . Note: Benefits for Prosthetic Devices for Artificial Arms and Legs can be found under <i>Orthotic Devices and Prosthetic Devices - Artificial Arms and Legs</i> in the <i>Additional Benefits Required by Texas Law Section</i> in this <i>Schedule of Benefits</i> .	Network 80% Non-Network 50%	Yes Yes	Yes Yes
23. Reconstructive Procedures			
Prior Authorization Requirement			
For Non-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500. In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		

[illegible]

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	80%	Yes	Yes
	Non-Network 50%	Yes	Yes
26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
Prior Authorization Requirement			
For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
Limited to 60 days per year.	Network 80%	Yes	Yes
	Non-Network 50%	Yes	Yes
27. Substance Use Disorder Services and Chemical Dependency Services			
Prior Authorization Requirement			
For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for services at a Residential Treatment facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Partial Hospitalization/Day Treatment; Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; medication assisted treatment programs for substance use disorder.			
If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
	Network Inpatient		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	80%	Yes	Yes
	Outpatient		
	100% after you pay a Copayment of \$30 per visit	Yes	No
	80% for Partial Hospitalization/Intensive Outpatient Treatment	Yes	Yes
	Non-Network		
	Inpatient		
	50%	Yes	Yes
	Outpatient		
	50%	Yes	Yes
	50% for Partial Hospitalization/Intensive Outpatient Treatment	Yes	Yes
28. Surgery - Outpatient			
Prior Authorization Requirement			
For Non-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
	Network		
	80%	Yes	Yes
	Non-Network		
	50%	Yes	Yes
29. Temporomandibular Joint Services			
Prior Authorization Requirement			
For Non-Network Benefits you must obtain prior authorization five business days before			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
30. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
	Network 80% Non-Network 50%	Yes Yes	Yes Yes
31. Transplantation Services			
Prior Authorization Requirement For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated			

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Facility, Network Benefits will not be paid. Non-Network Benefits will apply. For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500. In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).			
For Network Benefits, transplantation services must be received at a Designated Facility. We will refer you to the Designated Facility most suitable, in our opinion, to treat your condition. In the event that the selected Designated Facility is located outside of Texas and you do not wish to travel outside the state, we shall refer you to an alternate Designated Facility within the state of Texas. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
32. Urgent Care Center Services			
In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center: • Major diagnostic and nuclear medicine described under <i>Lab</i> .	Network 100% after you pay a Copayment of \$75 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.</p> <ul style="list-style-type: none">Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient.</i>Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic.</i>Outpatient surgery procedures described under <i>Surgery - Outpatient.</i>Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient.</i>	<p>Non-Network</p> <p>50%</p>	Yes	Yes
33. Virtual Visits			
Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.	<p>Network</p> <p>100% after you pay a Copayment of \$25 per visit</p> <p>Non-Network</p> <p>50%</p>	Yes <	

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Services category in this <i>Schedule of Benefits</i> .			
Hospital - Inpatient Stay and Skilled Nursing Facility/ Inpatient Rehabilitation Facility Services	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
Outpatient Post-Acute Care, Transitional Services and Rehabilitative Services	<p>Network</p> <p>100% after you pay a Copayment of \$30 per visit</p> <p>Non-Network</p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>Yes</p>
35. Amino Acid-Based Elemental Formulas	<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before amino acid-based formulas are received or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.</p>		
<p>If an <i>Outpatient Prescription Drug Rider</i> is included under this Policy, Benefits for the amino acid-based elemental formulas will be provided as described under the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Benefits will be provided as specified under this Benefit category:</p>	<p>Network</p> <p>80%</p>	<p>Yes</p>	<p>Yes</p>

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none">If an <i>Outpatient Prescription Drug Rider</i> is not included under the Policy.If any medically necessary services are provided in connection with the administration of the formula.	Non-Network 50%	Yes	Yes
36. Autism Spectrum Disorder Services			
Prior Authorization Requirement Depending upon where the Covered Health Service is provided, any applicable prior authorization requirements will be the same as those stated under each Covered Health Services category in this <i>Schedule of Benefits</i> .			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
37. Developmental Delay Services			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization five business days before receiving developmental delay services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
Benefits are paid at the same level as Benefits for any other Covered Health Service, except that the Benefit limit	Network Depending upon where the Covered Health Service is		

When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
for Rehabilitation Services - Outpatient Therapy and Manipulative Treatment does not apply to services for developmental delays.	provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits. Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
38. Human Papillomavirus, Cervical Cancer and Ovarian Cancer Screenings			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits. Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.		
39. Orthotic Devices and Prosthetic Devices - for Artificial Arms and Legs			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic or orthotic devices that exceed \$1,000 in cost per device. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.			
Benefits are limited to a single purchase of each type of prosthetic device every three years. Once this limit is reached, Benefits continue to be available for items required by the Women's Health and Cancer Rights Act of 1998.	Network 80%	Yes	Yes

<i>When Benefit limits apply, the limit refers to any combination of Designated Network Benefits, Network Benefits and Non-Network Benefits unless otherwise specifically stated.</i>			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 50%	Yes	Yes
40. Osteoporosis Detection and Prevention			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
41. Phenylketonuria and Other Heritable Diseases			
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Designated Network Benefits and Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you

and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For Designated Network Benefits and Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Designated Network and Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are an amount negotiated by us or an amount permitted by law. Please contact us if you are billed for amounts in excess of your applicable Coinsurance, Copayment or any deductible. We will not pay excessive charges or amounts you are not legally obligated to pay.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors.
 - If rates have not been negotiated, then one of the following amounts:
 - ♦ Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market, with the exception of the following:
 - 50% of *CMS* for the same or similar laboratory service.
 - 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
 - ♦ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
 - When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
 - ♦ For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a

psychologist and by 35% for Covered Health Services provided by a masters level counselor.

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of *CMS* for the same or similar laboratory service.
- 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The usual, reasonable or customary amount;
- The median amount negotiated with Network providers for the same service; or
- 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here, however, you should contact us if you receive such a bill and we will work with the provider so that you are only responsible for your Copayment, coinsurance or Deductible.

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility and/or a Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

When Covered Health Services are rendered to a Covered Person by a non-Network provider because there was not a Network provider reasonably available, we will:

- Pay the claim, at a minimum, at the usual, reasonable or customary charges for the Covered Health Service, less any applicable Coinsurance, Copayment or Annual Deductible amount;
- Pay the claim at the Network Benefit Coinsurance level; and
- In addition to any amount that would have been credited had the provider been a Network provider, credit any out-of-pocket amounts you paid to the non-Network provider for charges for Covered Health Services that were above and beyond the Eligible Expense toward the Annual Deductible and Out-of-Pocket Maximum applicable to Network services.

Limitations on Selection of Providers

If we determine that you are using health care services in a harmful or abusive manner, or with harmful frequency, your selection of Network providers may be limited. If this happens, we may require you to select a single Network Physician to provide and coordinate all future Covered Health Services.

If you don't make a selection within 31 days of the date we notify you, we will select a single Network Physician for you.

If you fail to use the selected Network Physician, Covered Health Services will be paid as Non-Network Benefits.

Continuity of Care

If you are undergoing a course of treatment from a Network provider at the time that Network provider is no longer contracted with us, you may be entitled to continue that care covered at the Network benefit level. Continuity of care is available in special circumstances in which the treating Physician or health care provider reasonably believes discontinuing care by the treating Physician could cause harm to the Covered Person. Special circumstances include Covered Persons with a disability acute condition, life-threatening illness or past the 24th week of Pregnancy. The continuity of care request must be submitted by the treating Physician or provider. If continuity of care is approved, it may not be continued beyond 90 days after the Physician or provider is no longer contracted with us, if the Covered Person has been diagnosed as having a terminal illness at the time of the termination, or the expiration of the nine month period after the effective date of the termination. If the Covered Person is past the 24th week of Pregnancy at the time of termination, coverage at the Network level will continue through the delivery of the child, immediate postpartum care and the follow-up checkup within the six week period after delivery. If you have questions regarding this transition of care reimbursement policy or would like help determining

whether you are eligible for transition of care Benefits, please contact Customer Care at the telephone number on your ID card.

Certificate of Coverage

UnitedHealthcare Insurance Company

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders, including the Outpatient Prescription Drug Rider and the Gender Dysphoria Rider.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing and agreed to by the Enrolling Group or required by state or federal law. These changes will not occur until the group goes through renewal and 60 days after prior notification is sent to you.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by Texas state law.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of Texas. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of Texas are the laws that govern the Policy.

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO

DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Any applicable deductible, Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses for non-Network expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us or assigning Benefits directly to that provider. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the authority to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 9: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where the required Emergency Health Services can be performed.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to the closest Network Hospital.
- To the closest Network Hospital or facility that provides Covered Health Services that were not available at the original Hospital or facility.
- From a short-term acute care facility to the closest Network long-term acute care facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network sub-acute facility.

For the purpose of this Benefit the following terms have the following meanings:

- "Long-term acute care facility (LTAC)" means a facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.
- "Short-term acute care facility" means a facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.
- "Sub-acute facility" means a facility that provides intermediate care on short-term or long-term basis.

2. Clinical Trials

Routine patient care costs incurred during participation in a qualifying phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and is described below:

- The trial is approved or funded by:
 - *The National Institutes of Health;*
 - *The Centers for Disease Control and Prevention;*
 - *The Agency for Health Care Research and Quality;*
 - *The Centers for Medicare and Medicaid Services;*
 - A group or center of the entities described above, or the *Department of Defense* or the *Department of Veterans Affairs;*
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
 - *The Department of Energy.*
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

3. Congenital Heart Disease Surgeries

Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.

4. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.
- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, or if not a Covered Person at the time of the accident, within the first three months of coverage under the Policy, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident, or if not a Covered Person at the time of the accident, within the first 12 months of coverage under the Policy.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

5. Diabetes Services

Diabetes equipment, diabetes supplies and diabetes self-management training programs when provided by or under the direction of a Doctor of Medicine, Doctor of Osteopathy or a Certified Diabetic Educator. Benefits also include new and improved diabetes equipment or supplies, including improved insulin and another prescription drug, approved by the United States Food and Drug Administration if the equipment or supplies are determined by a Physician or other health care practitioner to be Medically Necessary and appropriate. All supplies, including medications and equipment for the control of diabetes shall be dispensed as written, including brand name products, unless substitutions are approved by the Physician or practitioner who issues the written order.

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits are also provided for additional training upon diagnosis of a significant change in

medical condition that requires a change in the self-management regime and periodic continuing education training is warranted by the development of new techniques and treatment for diabetes.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.

Diabetic Self-Management Items

Diabetes equipment is limited to:

- Blood glucose monitors (including noninvasive glucose monitors and those designed to be used by or adapted for the legally blind).
- Insulin pumps, both external and implantable, and associated appurtenances which include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin and other required disposable supplies. Benefits are included for repairs and necessary maintenance of insulin pumps that are not otherwise provided for under warranty or purchase agreement. Benefits are also included for rental fees for pumps during the repair and necessary maintenance of insulin pumps (neither of which shall exceed the purchase price of a similar replacement pump).
- Podiatric appliances including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes.

Diabetes supplies are limited to:

- Test strips for blood glucose monitors.
- Visual reading and urine testing strips and tablets that test for glucose, ketones and protein.
- Lancet and lancet devices.
- Insulin and insulin analog preparations.
- Injection aids, including devices used to assist with insulin injection and needleless systems.
- Insulin syringes.
- Biohazard disposable containers.
- Glucagon emergency kits.
- Prescription and non-prescription oral agents for controlling blood sugar levels.

Note: If an *Outpatient Prescription Drug Rider* is included under the Policy, Benefits for the diabetes supplies above will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under this Benefit category of the *Certificate*.

6. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. This exclusion does not apply to orthotic devices as described under *Orthotic Devices and Prosthetic Devices - for Artificial Arms and Legs*. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

7. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility or Freestanding Emergency Medical Care Facility or comparable emergency facility to evaluate and stabilize a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury of such nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of bodily organ or part;

- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

If a Covered Person cannot reasonably reach a Network provider, we shall provide reimbursement for the following Emergency Health Services at the Network provider level of Benefits until the Covered Person can reasonably be expected to transfer to a Network provider:

- A medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility or a Hospital that is necessary to determine whether a medical emergency condition exists;
- Necessary Emergency Health Services, including the treatment and stabilization of an emergency medical condition; and
- Services originating in a Hospital emergency facility or Freestanding Emergency Medical Care Facility following treatment and stabilization of an emergency medical condition.

When Emergency Health Services are received in a Physician's office, the Benefits will be paid as described in *Physician's Office Services - Sickness and Injury* below.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment as well as medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an Emergency exists. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

8. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

If more than one type of hearing aid can meet your functional needs, Benefits are available only for the hearing aid that meets the minimum specifications for your needs.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this *Certificate*, only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

9. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.

- Provided in your home by a registered nurse, or a licensed vocational nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits include skilled nursing by a registered nurse or licensed vocational nurse; physical, occupational, speech or respiratory therapy; the service of a home health aide, under the supervision of a registered nurse; and medical equipment and medical supplies other than drugs and medicines.

10. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

11. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- We provide Benefits, at a minimum, for an Inpatient Stay of at least 48 hours following a mastectomy and for 24 hours following a lymph node dissection for the treatment of breast cancer. The Covered Person and the treating Physician may determine that a shorter period of inpatient care is appropriate.
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

12. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.
- Coverage for noninvasive screening tests for atherosclerosis and abnormal artery structure such as ultrasonography measuring carotid intima-media thickening and plaque.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

13. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans (including for the measuring of coronary artery calcification), PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

14. Mental Health Services and Serious Mental Illness Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.

- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

Mental Health Services under this section include services for the following psychiatric illnesses (defined as Serious Mental Illness in *Section 9: Defined Terms*):

- Schizophrenia.
- Paranoid and other psychotic disorders.
- Bipolar disorders (hypomanic, manic, depressive, and mixed).
- Major depressive disorders (single episode or recurrent).
- Schizo-affective disorders (bipolar or depressive).
- Obsessive-compulsive disorders.
- Depression in childhood and adolescence.

Benefits are provided for alternative Mental Health Services for treatment of a Serious Mental Illness in a Residential Treatment Center for Children and Adolescents or from a Crisis Stabilization Unit, as required by State of Texas insurance law.

We provide administrative services for all levels of care.

We encourage you to contact us for referrals to providers and coordination of care.

15. Neurobiological Disorders - Autism Spectrum Disorder Services

Behavioral services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as *Applied Behavioral Analysis (ABA)*) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a *Board Certified Applied Behavioral Analyst (BCBA)* or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under *Autism Spectrum Disorders*.

Medical treatment of Autism Spectrum Disorder for Covered Persons is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories in this Certificate of Coverage.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.

- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient Treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider-based case management services.
- Crisis intervention.

We provide administrative services for all levels of care.

We encourage you to contact us for referrals to providers and coordination of care.

16. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

17. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we may direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical

Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

18. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, via telemedicine or telehealth, or for Physician house calls.

Face to face contact is not required between a health care provider and a patient, for services to be appropriately provided through telemedicine or telehealth. Services provided by telemedicine and telehealth are subject to the same terms and conditions of the Policy for any service provided face to face.

19. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is freestanding, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Benefits also include necessary diagnostic and follow-up care relating to the screening test for hearing loss of newborn Dependents.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

20. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following an uncomplicated normal vaginal delivery.
- 96 hours for the mother and newborn child following an uncomplicated cesarean section delivery.
- 96 hours for the mother and newborn child following a non-elective cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames. If the discharge occurs earlier or if the delivery does not occur in a Hospital or other facility, Benefits are provided for post-delivery care provided by a Physician, a registered nurse or other appropriately licensed provider, either in the mother's home or at another location determined to be appropriate.

Post-delivery care includes services provided in accordance with accepted maternal and neonatal physical assessment, parent education, breast or bottle feeding, educational/training and performance of necessary and appropriate clinical tests.

21. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*. Women may access obstetrics and gynecology services directly from an obstetrician or gynecologist. You may receive these services without Prior Authorization or a referral from your Primary Care Physician.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.

- Duration of a rental.
- Timing of an acquisition.
- Preventive care includes the following:
 - Periodic health examinations for adults.
 - Immunizations for children, including but not limited to:
 - ♦ Diphtheria.
 - ♦ Haemophilus influenza type B.
 - ♦ Hepatitis B.
 - ♦ Measles.
 - ♦ Mumps.
 - ♦ Pertussis.
 - ♦ Polio.
 - ♦ Rubella.
 - ♦ Tetanus.
 - ♦ Varicella.
 - ♦ Any other immunization required for children by law.
 - Well-child care from birth.
 - Mammography screening for breast cancer.
 - Screening for prostate cancer.
 - Screening for colorectal cancer.
 - Screening for early detection of human papillomavirus and cervical cancer.
 - Eye and ear screenings for children as supported by HRSA.

Please contact us at the telephone number on the back of your ID card if you have any questions or you need assistance with determining whether a service is eligible for coverage as a preventive service.

For a comprehensive list of recommended preventive services, go to:
www.healthcare.gov.center.regulation/prevention.html.

22. Prosthetic Devices for other than Arms and Legs

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body other than breast prostheses.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most appropriate model of prosthetic device that meets your needs as determined by your treating Physician. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

23. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Benefits are provided for the reconstructive procedures for craniofacial abnormalities to improve the function of or attempt to create the normal appearance of, an abnormal structure caused by congenital defects, development of deformities, trauma, tumors, infections, or disease. (Benefits are not available for cranial banding, which is not a Covered Health Service.)

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses treatment of physical complications including lymphedemas at all stages of mastectomy, mastectomy bras, lymphedema stockings for arms and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

24. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services (including habilitative services), limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.

- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility. Rehabilitative services provided in a Covered Person's home by a Home Health Agency are provided as described under *Home Health Care*. Rehabilitative services provided in a Covered Person's home other than by a Home Health Agency are provided as described under this section.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits under this section are not available for maintenance/preventive treatment.

For outpatient rehabilitation services for speech therapy, we will pay Benefits for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

Benefits are available only for rehabilitation services that are expected to restore a Covered Person to the previous level of functioning (not to exceed activities of daily living). Benefits for rehabilitation services are not available for services that are expected to provide a higher level of functioning than the Covered Person previously possessed. For a physically disabled person, treatment goals may include maintenance of functioning or prevention of or slowing of further deterioration.

Habilitative Services

For the purpose of this Benefit, "habilitative services" means Medically Necessary skilled health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative services are skilled when all of the following are true:

- The services are part of a prescribed plan of treatment or maintenance program that is Medically Necessary to maintain a Covered Person's current condition or to prevent or slow further decline.
- It is ordered by a Physician and provided and administered by a licensed provider.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. Therapies provided for the purpose of general well-being or conditioning in the absence of a disabling condition are not considered habilitative services. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist or Physician.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and Residential Treatment are not habilitative

services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

25. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and diagnostic endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

26. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.

- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

27. Substance Use Disorder Services and Chemical Dependency Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a provider's office. Substance Use Disorder Services include services for Chemical Dependency as required by Texas state law and/or regulation. All services must be provided by or under the direction of a properly qualified behavioral health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential Treatment.
- Partial Hospitalization/Day Treatment.
- Intensive Outpatient Treatment.
- Outpatient treatment.

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family, and group therapy.
- Provider -based case management services.
- Crisis intervention.

Benefits under this category include Chemical Dependency services as required under State of Texas insurance law. Benefits include detoxification from abusive chemicals or substances, limited to physical detoxification when necessary to protect your physical health and well-being. (Detoxification is the process of withdrawing a person from a specific psychoactive substance in a safe and effective manner.)

We provide administrative services for all levels of care.

We encourage you to contact us for referrals to providers and coordination of care.

28. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Blood, including cost of blood, blood plasma, and blood plasma expanders.

29. Temporomandibular Joint Services

Benefits are provided for services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles, including the jaw and the craniomandibular joint, which are required as a result of an accident, trauma, congenital defect, developmental defect, or pathology.

Benefits include the following:

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of a dislocation of, excision of, and injection of the temporomandibular joint. Benefits for surgical services also include *FDA*-approved TMJ implants only when all other treatment has failed.

30. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

31. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

32. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

33. Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email, fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (*CMS* defined originating facilities).

Additional Benefits Required By Texas Law

34. Acquired Brain Injury

Benefits are provided for Covered Health Services that are determined by a Physician to be Medically Necessary as a result of and related to an acquired brain injury. Acquired brain injury is a neurological insult to the brain which is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior. Benefits are provided for the Covered Health Services listed below when they are clinically proven, goal-oriented, efficacious, based on individualized treatment plans, required for and related to treatment of an acquired brain injury and provided by or under the direction of a Physician with the goal of returning the Covered Person to, or maintaining the Covered Person in, the most integrated living environment appropriate to the Covered Person.

- Cognitive communication therapy. Services designed to address modalities of comprehension and expression, including understanding, reading, writing and verbal expression of information.
- Cognitive rehabilitation therapy. Services designed to address therapeutic cognitive activities based on an assessment and understanding of the individual's brain-behavioral deficits.
- Community reintegration services. Services that facilitate the continuum of care as an affected individual transitions into the community.
- Neurobehavioral testing. An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and pre-morbid history including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.
- Neurobehavioral treatment. Interventions that focus on behavior and the variables that control behavior.
- Neurocognitive rehabilitation. Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
- Neurocognitive therapy. Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
- Neurofeedback therapy. Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
- Neurophysiological testing. An evaluation of the functions of the nervous system.
- Neurophysiological treatment. Interventions that focus on the functions of the nervous system.
- Neuropsychological testing. The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
- Neuropsychological treatment. Interventions designed to improve or minimize deficits in behavioral and cognitive processes.
- Outpatient day treatment services - Structured services provided to address deficits in physiological, behavioral and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

Post-acute care treatment services - Services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-acute care services necessary as a result of and related to an acquired brain injury are limited to the following: post-acute care treatment is limited to reasonable expenses related to periodic reevaluation of care provided to an individual who has incurred an acquired brain injury, has been unresponsive to treatment and becomes responsive to treatment at a later date. Reasonable costs may be determined by cost; the time that has expired since the previous evaluation; any difference in the expertise of the Physician or practitioner performing the evaluation; changes in technology and advances in medicine. For services provided by a licensed Assisted Living Facility through a program that includes an overnight stay, each overnight stay is equal to a visit.

- Post-acute transition services. Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

- Psychophysiological testing. An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.
- Psychophysiological treatment. Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
- Remediation. The process of restoring or improving a specific function.
- Treatment facilities. Treatment for an acquired brain injury may be provided at a facility at which the services listed above may be provided including a Hospital, acute or post-acute rehabilitation hospital and Assisted Living Facility. Although Benefits may be available for services at Assisted Living Facilities, Benefits are not available for Custodial Care, Private Duty Nursing, domiciliary care, and personal care assistants as outlined in *Types of Care* in *Section 2: Exclusions and Limitations* in this *Certificate of Coverage*, regardless of where the services are provided.

35. Amino Acid-Based Elemental Formulas

Benefits are provided for amino acid-based elemental formulas, regardless of the formula delivery method, that are used for the diagnosis and treatment of:

- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins.
- Severe food protein-induced enterocolitis syndrome.
- Eosinophilic disorders, as evidenced by the results of a biopsy.
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.

Benefits will also be provided for any Medically Necessary services associated with the administration of the formula.

If an *Outpatient Prescription Drug Rider* is included under the *Policy*, Benefits for the amino acid-based elemental formulas will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under this category of this *Certificate*.

For Benefits to be provided, the treating Physician must issue a written order stating that the amino acid-based elemental formula is Medically Necessary for the treatment of a Covered Person who is diagnosed with at least one of the diseases or disorders listed above.

36. Autism Spectrum Disorder Services

Benefits for Autism Spectrum Disorder Services include coverage for screening a child for Autism Spectrum Disorder.

Benefits are provided for Covered Health Services for an Enrolled Dependent child who has been diagnosed with an Autism Spectrum Disorder.

Benefits are provided for generally recognized services listed below when prescribed by the Enrolled Dependent child's Primary Physician in the treatment plan recommended by that Physician. Benefits for psychiatric treatment for Autism Spectrum Disorder (including evaluation and assessment services, applied behavior analysis and behavior training and behavior management) are prescribed above under *Neurobiological Disorders - Autism Spectrum Disorder Services*.

- Evaluation and assessment services.
- Speech therapy.
- Occupational therapy.

- Physical therapy.
- Medications and nutritional supplements used to address symptoms of Autism Spectrum Disorder.

The individual providing generally recognized services must be a health care practitioner who is licensed, certified, or registered by an appropriate agency of the State of Texas, whose professional credentials are recognized and accepted by an appropriate agency of the United States; who is certified as a provider under the TRICARE military health system.

Please note that medical treatment of Autism Spectrum Disorders for all other Covered Persons is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services Benefit categories in the *Certificate*.

37. Developmental Delay Services

Rehabilitative and habilitative services that are determined to be necessary to, and provided in accordance with, an individualized family service plan issued by the Interagency Council on Early Childhood Intervention. Covered Health Services include:

- Occupational therapy evaluations and services.
- Physical therapy evaluations and services.
- Speech therapy evaluations and services.
- Dietary or nutritional evaluations.

38. Human Papillomavirus, Cervical Cancer Screenings and Ovarian Cancer Screenings

Benefits for human papillomavirus, cervical cancer screenings and ovarian cancer screenings will be provided to each woman 18 years of age and older that is an Eligible Person enrolled under the Contract for coverage. Coverage includes the following:

- An annual medically recognized diagnostic examination for the early detection of cervical cancer;
- A conventional pap smear screening or a screening using liquid-based cytology methods, as approved by the *United States Food and Drug Administration (FDA)*, alone or in combination with a test approved by the *FDA* for the detection of the human papillomavirus.
- An annual CA 125 blood test for the early detection of ovarian cancer.
- Screenings provided under this section must be performed in accordance with the guidelines adopted by:
 - *The American College of Obstetricians and Gynecologists*; or
 - Another similar national organization of medical professionals recognized by the commissioner.

39. Orthotic Devices and Prosthetic Devices - for Artificial Arms and Legs

Orthotic devices and Prosthetic devices and provider services related to the fitting and use of the prosthetic. For the purposes of this provision:

- "Prosthetic device" means an artificial device designed to replace, wholly or partially, an arm or leg.

- "Orthotic device" means a custom-fitted or custom-fabricated medical device that is applied to part of the human body (not limited to an arm and leg) to correct a deformity, improve function, or relieve symptoms of a disease.

If more than one prosthetic or orthotic device can meet your functional needs, Benefits are available only for the most appropriate model of prosthetic or orthotic device that meets your needs, as determined by your treating Physician. If you purchase a prosthetic or orthotic device that exceeds these specifications, we will pay only the amount that we would have paid for the prosthetic or orthotic device that meets the specifications, and you will be responsible for paying any difference in cost.

The prosthetic or orthotic device must be ordered or provided by, or under the direction of a Physician. The devices must not be solely for comfort or convenience.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost prosthetic or orthotic devices.

Covered Health Services under this section may be provided by a pharmacy with employees who are qualified under the Medicare system and applicable Medicaid regulations to service and bill for orthotic services.

40. Osteoporosis Detection and Prevention

Benefits for a medically accepted bone mass measurements for the detection of low bone mass, when provided by or under the direction of a Physician. Benefits are provided only to a Covered Person who meets at least one of the following:

- A postmenopausal woman who is not receiving estrogen replacement therapy.
- An individual with vertebral abnormalities, primary hyperparathyroidism, or history of bone fractures.
- An individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

41. Phenylketonuria and Other Heritable Diseases

Benefits are provided for formulas necessary to treat phenylketonuria or heritable diseases.

Heritable disease means an inherited disease that may result in mental or physical retardation or death.

Phenylketonuria (PKU) means an inherited condition that, if not treated, may cause severe mental retardation.

If an *Outpatient Prescription Drug Rider* is included under the Policy, Benefits for the phenylketonuria or other heritable diseases will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under this category of this *Certificate*.

Benefits for Phenylketonuria and other heritable diseases will be paid the same as other drugs that are available when prescribed by a Physician.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.
- Services required by a Covered Person who is unable to undergo dental treatment in an office setting or under local anesthesia because of a documented physical, mental or medical reason.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement or the *Health Resources and Services Administration (HRSA)* requirement. This exclusion also does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to orthotic devices as described under *Orthotic Devices and Prosthetic Devices for Artificial Arms and Legs* in *Section 1: Covered Health Services*.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.

- Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech.
 6. Oral appliances for snoring.
 7. Repairs to prosthetic or orthotic devices due to misuse, malicious damage or gross neglect.
 8. Replacement of prosthetic or orthotic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill. This exclusion does not apply to prescription and non-prescription oral agents for controlling blood sugar levels. Note: If an *Outpatient Prescription Drug Rider* is included under the *Policy*, Benefits for the prescription and non-prescription oral agents will be provided under the *Outpatient Prescription Drug Rider*. Otherwise, the Benefits will be provided under the *Certificate*.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting. This exclusion does not apply to self-injectable medications for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter drugs and treatments for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
5. Growth hormone therapy.
6. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.
7. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
8. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
9. A Pharmaceutical Product with an approved biosimilar or a biosimilar and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. For the purpose of this exclusion a "biosimilar" is a biological Pharmaceutical Product approved based on showing that it is highly similar to a reference product (a biological Pharmaceutical Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations may be made up to six times per calendar year.

10. Certain Pharmaceutical Products for which there are therapeutically equivalent (having essentially the same efficacy and adverse effect profile) alternatives available, unless otherwise required by law or approved by us. Such determinations may be made up to six times during a calendar year.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe orthotics. This exclusion does not apply to podiatric appliances or therapeutic footwear as described under *Diabetes Services* or *Orthotic Devices and Prosthetic Devices - for Artificial Arms and Legs* in *Section 1: Covered Health Services*.
8. Shoe inserts.
9. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - Compression stockings.
 - Ace bandages.
 - Gauze and dressings.
 - Urinary catheters.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
 - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
 - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health, Neurobiological/Autism Spectrum, and Substance Use Disorder Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Outside of initial assessment, services as treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, pyromania, kleptomania, gambling disorder, and paraphilic disorder.
4. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
5. Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
6. Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Transitional Living services.

I. Nutrition

1. Individual and group nutritional counseling, including non-specific disease nutritional education such as general good eating habits, calorie control or dietary preferences. This exclusion does not apply to preventive care for which Benefits are provided under the *United States Preventive Services Task Force* requirement. This exclusion also does not apply to medical nutritional education services that are provided as part of treatment for a disease by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

2. Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to amino-acid based elemental formulas as described under *Amino Acid-Based Elemental Formulas* in *Section 1: Covered Health Services*.
3. Infant formula and donor breast milk. This exclusion does not apply to amino-acid based elemental formulas as described under *Amino Acid-Based Elemental Formulas* in *Section 1: Covered Health Services*.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to:
 - Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in *Section 1: Covered Health Services*, which meet the definition of a Covered Health Service.
 - Amino acid-based elemental formulas as described under *Amino Acid-Based Elemental Formulas* in *Section 1: Covered Health Services*.
 - Formulas for phenylketonuria (PKU) or other heritable diseases.

J. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.
 - Home modifications such as elevators, handrails and ramps.
 - Hot and cold compresses.
 - Hot tubs.
 - Humidifiers.
 - Jacuzzis.
 - Mattresses.
 - Medical alert systems.
 - Motorized beds.

- Music devices.
- Personal computers.
- Pillows.
- Power-operated vehicles.
- Radios.
- Saunas.
- Stair lifts and stair glides.
- Strollers.
- Safety equipment.
- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

K. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

L. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Rehabilitation services for speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.
9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback. This exclusion does not apply when the service is rendered with the diagnosis of acquired brain injury.
11. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
12. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea.
13. Surgical and non-surgical treatment of obesity.
14. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
15. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.
16. In vitro fertilization regardless of the reason for treatment.

M. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself. This exclusion does not apply to dentists.
2. Services performed by a provider with your same legal residence. This exclusion does not apply to dentists.

3. Services provided at a Freestanding Facility or diagnostic Hospital-based Facility without an order written by a Physician or other provider. Services which are self-directed to a Freestanding Facility or a diagnostic Hospital-based Facility. Services ordered by a Physician or other provider who is an employee or representative of a Freestanding Facility or diagnostic Hospital-based Facility, when that Physician or other provider:
 - Has not been actively involved in your medical care prior to ordering the service, or
 - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

N. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.

O. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy.
3. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
4. Health services while on active military duty.

P. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

Q. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services*.

R. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

S. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction.
3. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Bone anchored hearing aids except when either of the following applies:
 - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
 - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

T. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services,

including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
 - Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, all forms of vaccinations and immunizations or treatments that are otherwise covered under the Policy when:
 - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.
 - Required to obtain or maintain a license of any type.
 3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
 4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
 5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
 6. In the event a non-Network provider waives, does not pursue, or fails to collect Copayments, Coinsurance, any deductible, or other amount owed for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
 7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
 8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
 9. Autopsy.
 10. Foreign language and sign language services.
 11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

If You Are Eligible for Medicare

Your Benefits under the Policy may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B.

Your Benefits under the Policy may also be reduced if you are enrolled in a *Medicare Advantage* (Medicare Part C) plan but fail to follow the rules of that plan. Please see *Medicare Eligibility* in *Section 8: General Legal Provisions* for more information about how Medicare may affect your Benefits.

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

Eligible Persons must reside within the United States.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Open Enrollment Period

The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- The Subscriber is a party in a suit seeking adoption.
- The date the adoption becomes final.
- Marriage.
- Legal guardianship.
- Court or administrative order, including a Qualified Medical Child Support Order for a Dependent Child, regardless of whether or not the child resides within the Service Area.
- Domestic Partner.

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

Coverage for a new Dependent child by birth or adoption begins on the date of the event and remains in effect for 31 days. To continue coverage beyond the initial 31-day period, the Subscriber must notify us of the event and pay any required Premium within 31 days of the event. Benefits for Covered Health

Services for congenital defects and birth abnormalities (including Congenital Anomalies) are available at the same level as those for any other Sickness or Injury.

Coverage for a Dependent child when required by a medical support order begins on the date of receipt of either the medical support order, or the notice of the medical support order, and remains in effect for 31 days. To continue coverage beyond the initial 31-day period, we must receive a completed enrollment form and payment of any required Premium within 31 days of receipt of the medical support order. The Subscriber, the custodial parent, a child support agency, or the Dependent child (if over age 18) may complete and sign the enrollment form on behalf of the Dependent child. If the Eligible Person is not already enrolled, he or she is also eligible to enroll if required by a medical support order to provide health care coverage to his or her Dependent child. The Eligible Person must provide proof, satisfactory to us, of the requirement to provide health care coverage.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- The Subscriber is a party in a suit seeking adoption.
- The date the adoption becomes final.
- Marriage.
- Court or administrative order.
- Domestic Partner.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including divorce or death) as well as a child of a covered employee who has lost coverage under Chapter 62 Health and Safety Code, Child Health Plan for Certain Low-Income Children or Title XIX of the Social Security Act (42 U.S.C. §§1396, et seq., Grants to States for Medical Assistance Programs) other than coverage consisting solely of

benefits under Section 1928 of that Act (42 U.S.C. §1396, Program for Distribution of Pediatric Vaccines).

- The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
- In the case of COBRA continuation coverage, the coverage ended.
- The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
- The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
- An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
- The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above. Coverage for a newborn or newly adopted Dependent child is effective even if we do not receive an enrollment form or the required Premium as described below.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended). Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

Please note that for Covered Persons who are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

- For Texas residents, your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent and we receive written notice from the Enrolling Group instructing us to end your coverage consistent with Texas regulatory requirements. For non-Texas residents, your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**

For Texas residents, your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan and we receive written notice from the Enrolling Group instructing us to end your coverage consistent with Texas regulatory requirements. For non-Texas residents, your coverage end on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. If your coverage ends for this reason, we will provide you 30 days prior written notice.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Extended Coverage for Total Disability

Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- 90 days from the date coverage would have ended when the entire Policy was terminated.

Continuation of Coverage

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Continuation of Coverage under State Law

You may elect state continuation as described under the State Continuation Coverage provisions below.

Qualifying Events for State Continuation Coverage Due to Reasons other than Severance of the Family Relationship

A Covered Person whose coverage terminates due to any reason except involuntary termination for cause, and who has been continuously covered under the Policy (and under any group contract providing similar services and benefits that it replaced) for at least three consecutive months immediately prior to termination, is entitled to continue coverage under state law. A person whose coverage terminates due to severance of the family relationship may either continue coverage as described immediately below, or if he or she meets the requirements described in *Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship*, may continue coverage as described in that provision.

Notification Requirements, Election Period and Premium Payment for State Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

The Covered Person must provide a written request for continuation coverage to the Enrolling Group's designated Plan Administrator within 60 days after the later of these dates:

- The date group coverage would otherwise terminate.
- The date the Covered Person is given notice of the right to elect continuation.

The Covered Person must pay the initial Premium for the continuation coverage to the Enrolling Group's designated Plan Administrator within 45 days after the date of the initial election of coverage continuation. Following the payment of the initial Premium, the Covered Person must pay the monthly Premium for the coverage continuation to the designated Plan Administrator each month. Payment of the monthly continuation Premium will be considered timely if made on or before the 30th day after the date on which the payment is due.

Terminating Events for State Continuation Coverage Due to Reasons Other than Severance of the Family Relationship

State Continuation coverage due to reasons other than severance of the family relationship will end on the earliest of the following dates:

- Nine months from the date state continuation coverage was elected, if the Covered Person is not eligible for continuation of coverage under Federal law (COBRA).
- Six months from the date state continuation coverage was elected, if the state continuation coverage followed continuation coverage under Federal law (COBRA).
- The date coverage ends for failure to make timely payment of the Premium.

Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship

If both of the following are true, a Covered Person whose coverage terminates may elect state continuation coverage under the Policy:

- The Covered Person has been covered under the Policy for at least one year, or is an infant under one year of age.
- The Covered Person's coverage under the Policy was terminated for one of the reasons set forth below:
 - Termination of the Subscriber from employment with the Enrolling Group.
 - Death of the Subscriber.
 - Divorce of the Subscriber.
 - Retirement of the Subscriber.

Notification Requirements, Election Period and Premium Payment for State Continuation Coverage Due to Severance of the Family Relationship

A Covered Person must provide written notice to the Enrolling Group within 15 days of any severance of the family relationship that might qualify for the continuation as described in *Qualifying Events for State Continuation Coverage Due to Severance of the Family Relationship*. Upon receipt of such notice, or upon receipt of notice of the Subscriber's death or retirement, the Enrolling Group shall immediately give written notice of the right to state continuation to each affected Enrolled Dependent. Within 60 days of severance of the family relationship or the Subscriber's death or retirement, the Enrolled Dependent must give written notice to the Enrolling Group of his or her intent to elect state continuation. Coverage under the Policy remains in effect during the 60-day election period, provided the required Premium is paid. The Covered Person must pay the monthly Premium for the coverage continuation to the designated Plan Administrator each month. Payment of the monthly continuation Premium will be considered timely if made on or before the 30th day after the date on which the payment is due.

Termination Events for State Continuation Coverage Due to Severance of the Family Relationship

State continuation coverage due to severance of the family relationship will end on the earliest of the following dates:

- Three years from the date that the family relationship was severed or the date of the Subscriber's death or retirement.
- The date the Covered Person fails to make timely payment of the Premium.
- The date the Covered Person becomes eligible for substantially similar coverage under another health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or by any other plan or program.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within 15 months of the date of service, Benefits for that health service will be denied or reduced. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology (CPT)* codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

Payment of Benefits

If a Subscriber provides written authorization to pay Benefits to the Physician or other health care provider and provides it to us with a claim for benefits, all or a portion of any Eligible Expenses due to a provider may be paid directly to the provider instead of being paid to the Subscriber. But we will not reimburse third parties that have purchased or been assigned benefits by Physicians or other providers.

Benefits will be paid to you, your designated beneficiary, your estate, or if you are a minor or otherwise not competent to give a valid release, your parent, guardian, or other person actually support you, unless either of the following is true:

- The provider notifies us that your signature is on file, assigning benefits directly to that provider.
- You make a written request at the time you submit your claim.

Payment/Reimbursement for Certain Publicly Provided Services

As required by Texas law, we will pay Benefits on behalf of a child to the Texas Department of Human Services, if;

- The parent who purchased the Policy or who is required to pay child support by a court order or court-approved agreement is:
 - a possessory conservator of the child under a court order issued in this state; or
 - not entitled to possession or access to the child.
- The Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or 32, Human Resources Code; and
- We are notified, through an attachment to the claim for Benefits at the time the claim is first submitted, that the Benefits must be paid directly to the Texas Department of Human Services.

Payment/Reimbursement of Benefits to Conservator of Minor

As required by Texas law, we will pay Benefits to a court appointed possessory or managing conservator of a child if the court appointed person includes the following information when submitting a claim to us;

- Written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made; and
- A certified copy of a court order designating the person as a possessory or managing conservator of the child or other evidence designated by rule of the commissioner that the person is eligible for the benefits as this section provides.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the telephone, he/she can help you prepare and submit a written complaint.

We shall promptly investigate each complaint. The total time for acknowledgement, investigation and resolution of the complaint shall not exceed 30 calendar days after we receive the written complaint or the one-page complaint form.

Complaints concerning presently occurring Emergencies or denials of continued stays for hospitalization shall be investigated and resolved in accordance with the medical immediacy, and shall not exceed one business day from receipt of the complaint.

We shall not engage in any retaliatory action against any Covered Person. We shall not retaliate for any reason including, for example, cancellation of coverage or refusal to renew coverage because the Covered Person or person acting on behalf of the Covered Person has filed a complaint against the Policy or has appealed a decision.

How to Appeal a Claim Decision

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require prior notification or benefit confirmation prior to receiving medical care. If your appeal relates to a non-clinical denial, refer to *How to Appeal a Non-Clinical Benefit Determination* below.

How to Request an Appeal

If you disagree with either a pre-service request for Benefits determination, post-service claim determination or a rescission of coverage determination, you can contact us in writing to formally request an appeal.

Your request for an appeal should include:

- The patient's name and the identification number from the ID card.

- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision for you to receive services is between you and your Physician.

Your first appeal request must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits or the claim denial.

Prior Authorization of Services

A request for prior authorization of services is a notification to us of proposed services that will result in one of the following:

- A Pre-authorization;
- An Adverse Determination; or
- When there are no clinical issues for us to determine, a confirmation of receipt of your request.

If you receive an Adverse Determination in response to your request for prior authorization of services, you may appeal the decision. Please refer to *Procedures for Appealing an Adverse Determination* below. If you receive a pre-service Non-clinical Benefit Determination from us in response to your request for prior authorization of services, you may appeal our decision. Please refer to *How to Appeal a Non-Clinical Benefit Determination* below.

For procedures associated with urgent requests for prior authorization of services, see *Urgent Appeals that Require Immediate Action* below.

Procedures for Appealing an Adverse Determination

An Adverse Determination is a decision that is made by us or our agent that the health care services furnished or proposed to be furnished to a Covered Person are:

- Not medically necessary or appropriate.
- Experimental or Investigational Services.

An Adverse Determination includes a decision by us not to furnish a prescribed drug that your Physician determines is medically necessary. A complete definition of Adverse Determination is contained in *Section 9: Defined Terms*.

If you receive an Adverse Determination in response to a claim or a request for prior authorization of services, you, your designated representative or your provider of record may contact us orally or in writing to formally request an appeal.

If you, your designated representative or your provider of record orally appeal the Adverse Determination, we or our utilization review agent will send you, your designated representative or your provider of record a one-page appeal form.

If you, your designated representative or your provider of record chose to appeal in writing, your request for an Adverse Determination appeal should include:

- The patient's name and the identification number from the ID card.

- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Upon receipt of your appeal we will, within five working days, send you a letter acknowledging receipt of your appeal and provide you with a description of the Adverse Determination appeal process and a list of documents necessary to process your appeal.

Our review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Within two working days after the utilization review agent receives a request for a utilization review and all the information necessary to complete the review, an Adverse Determination Notice will be provided to you, your designated representative or your provider of record.

Time for Notice of Adverse Determination

A utilization review agent shall provide notice of an Adverse Determination as follows:

- With respect to a patient who is hospitalized at the time of the Adverse Determination, within one working day by either telephone or electronic transmission to the provider of record, followed by a letter within three working days notifying the patient and the provider of record of the Adverse Determination;
- With respect to a patient who is not hospitalized at the time of the Adverse Determination, within three working days in writing to the provider of record and the patient; or
- Within the time appropriate to the circumstances relating to the delivery of the services to the patient and the patient's condition, provided that when denying post-stabilization care subsequent to emergency treatment as requested by a treating Physician or other health care provider, notice will be provided to the treating Physician or other health care provider no later than one hour after the time of the request.
- A utilization review agent shall provide notice of an Adverse Determination for a concurrent review of the provision of the prescription drug or intravenous infusions for which the patient is receiving health benefits under this Policy no later than the 30th day before the date on which the provision of prescription drugs or intravenous infusion will be discontinued.

Denied Appeals Specialty Provider Review

If we uphold the clinical appeal, your provider may, within 10 working days of the appeal denial, request a review by a specialty provider by submitting a written request showing good cause for the additional review.

Independent Review Organization

If the appeal of an Adverse Determination is denied by us or our utilization review agent, you, your designated representative or your provider of record have the right to request a review of that decision by an Independent Review Organization (IRO).

If all of the following apply, you may request a review of a clinical benefit determination or an Adverse Determination by an IRO:

- Your complaint relates to a clinical benefit determination or an Adverse Determination.
- The clinical benefit determination or Adverse Determination is upheld.
- You have exhausted the clinical appeal procedure as described above.

When we or our utilization review agent notifies you, your designated representative or your provider of record that the appeal of the Adverse Determination has been denied:

- We or our utilization review agent will provide to you, your designated representative or your provider of record information on how to appeal the denial of an Adverse Determination to an IRO.
- We or our utilization review agent will send you, your designated representative or your provider of record the form or forms that must be completed and returned to us or our utilization review agent to begin the independent review process.
- After we receive a request for a review by an IRO, we will notify the Texas Department of Insurance (TDI) within one working day from the date the request for an independent review is received.
- We or our utilization review agent will provide a copy of any medical records relevant to the review, any documents used to make the determination, written notification, and any other documents submitted in support of the appeal to the IRO no later than the third business day after the request for review is received.
- TDI will, within one working day of receipt of a complete request for an independent review, randomly assign an IRO to conduct an independent review.
- In circumstances involving a life-threatening condition or an urgent care situation, if we have failed to meet the internal appeal process timeframes stated above, or if you are denied prescription drugs or intravenous infusion for which you are receiving benefits you are entitled to an immediate review by an IRO. In life-threatening or urgent care situations, you, your designated representative or your provider of record may contact us or our utilization review agent by telephone to request the review by the IRO and we or our utilization review agent will provide the required information. A determination will be made no later than the earlier of the following:
 - The third day after the date that the IRO receives the necessary information to make the determination; or
 - The third day after the date the IRO receives the request for the determination be made (or by the eighth day after the IRO receives the request if the review involves a health care service provided by a person eligible for workers' compensation medical benefits).
- For non-life threatening conditions the determination will be made on the 15th day after the date the IRO receives the information necessary to make the determination; or on the 20th day after the date the IRO receives the request that the determination be made.

We will pay for the costs relating to this review and will comply with the decision. You may request a review by an IRO without exhausting the appeal procedure if the Adverse Determination relates to a life-threatening condition or an urgent care situation.

Retrospective Review

If the Adverse Determination relates to a retrospective review, you will receive notice no later than 30 days after we receive your claim. We may extend this period for up to an additional 15 days if we determine an extension is necessary due to matters beyond our control. If an extension is needed, you will be notified within 30 days after we receive your claim. If the extension is necessary because we have not received information from you or your provider, we will specifically describe the information needed and allow 45 days for the information to be submitted. We will make a decision within 30 days of the date of the extension notice until the earlier of the date you or your provider respond to the request for additional information or the date the information was to be submitted.

Expedited Appeal for Denial of Emergency Care, Continued Hospitalization, Prescription Drugs or Intravenous Infusions

Procedures for written expedited appeals of an Adverse Determination for denials of Emergency Care, continued hospitalization, Prescription Drugs or intravenous infusions will include a review by a health care provider who:

- Has not previously reviewed the case; and
- Is the same or a similar specialty as the health care provider who would typically manage the medical or dental condition, procedure, or treatment under review in the appeal.

The time for resolution of an expedited appeal is based on the medical or dental immediacy of the condition, procedure, or treatment under review, provided that the resolution of the appeal may not exceed one working day from the date all information necessary to complete the appeal is received.

The expedited appeal determination may be provided by telephone or electronic transmission, but must be followed with a letter within three working days of the initial telephonic or electronic notification.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will notify you of the decision by the end of the next business day following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.
- The appeal process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.
- If you are not satisfied with our decision, you have a right take your complaint to the *Texas Department of Insurance*.

How to Appeal a Non-Clinical Benefit Determination

If you receive a benefit denial in response to a request for prior authorization of services or as a result of a post service claim determination, you, your designated representative or your provider of record can contact us orally or in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Non-clinical Benefit Determination is a determination made by us that proposed or delivered services are or are not covered services according to the terms of the insurance policy without reference to the medical necessity or appropriateness of the services. A Non-clinical Benefit Determination that services are not covered is not an Adverse Determination.

For appeals of Non-clinical Benefit Determinations and post service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

- A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - 1. Plan includes: group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
- B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
- C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after

those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense. A contract may not reduce benefits on the basis that: another Plan exists and the Covered Person did not enroll in that Plan; a person is or could have been covered under another Plan, except with respect to Part B of Medicare; or a person has elected an option under another Plan providing a lower level of benefits than another option that could have been elected.

- D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
 2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 - 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.
 - 2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care

coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

- (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.
- c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
- d) (i) For a dependent child who has coverage under either or both parents' plans and also has his or her own coverage as a dependent under a spouse's plan, the rule in paragraph (5) applies.
 - (ii) In the event the dependent child's coverage under the spouse's plan began on the same date as the dependent child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in subparagraph (a) to the dependent child's parent(s) and the dependent's spouse.
3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, should the plan wish to coordinate benefits, the Secondary Plan must calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The

Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, results in the total benefits paid or provided by all plans for the claim equaling 100 percent of the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.
- C. If the Primary Plan is a Closed Panel plan and the Secondary Plan is not, the Secondary Plan must pay or provide benefits as if it were the Primary Plan when a Covered Person uses a non-Network Physician, except for emergency services or authorized referrals that are paid or provided by the Primary Plan.
- D. When multiple contracts providing coordinated coverage are treated as a single plan under this subchapter, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan must be responsible for the plan's compliance with this subchapter.
- E. If a person is covered by more than one Secondary Plan, the order of benefit determination rules of this subchapter decide the order in which Secondary Plans' benefits are determined in relation to each other. Each Secondary Plan must take into consideration the benefits of the Primary Plan or plans and the benefits of any other Plan that, under the rules of this subchapter, has its benefits determined before those of that Secondary Plan.
- F. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare Part B. Medicare benefits are determined as if the person were covered under Medicare Part B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare.

Important: If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under this Coverage Plan), you should enroll for and maintain coverage under Medicare Part B. If you don't enroll and maintain that coverage, and if we are secondary to Medicare, we will pay Benefits under this Coverage Plan as if you were covered. As a result, your out-of-pocket costs will be higher.

If you have not enrolled in Medicare Part B, Benefits will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider if either of the following applies:

- You are eligible for, but not enrolled in, Medicare Part B and this Coverage Plan is secondary to Medicare.

- You have enrolled in Medicare but choose to obtain services from a doctor that opts-out of the Medicare program.

When calculating this Coverage Plan's Benefits in these situations for administrative convenience, we may treat the provider's billed charges, rather than the Medicare approved amount or Medicare limiting charge, as the Allowable Expense for both this Coverage Plan and Medicare.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. §1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

In accordance with state and federal law, we will do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

We may delegate this authority to other persons or entities that provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, we reserve the right, without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. These changes are effective at renewal and only after a 60-day written notice has been sent to the Enrolling Group and to the Commissioner. All of the following conditions apply:

- Amendments.

- Riders.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Medicare Eligibility

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Subrogation

Subrogation applies when we have paid Benefits on your behalf for a Sickness or Injury for which a third party is considered responsible. The right to subrogation means that we are substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits we have paid that are related to the Sickness or Injury for which a third party is considered responsible.

Reimbursement

Reimbursement is the payment by you out of the recovery received from any third party to us to be limited to the amount of medical Benefits paid by us. We may request and receive reimbursement of any type of recovery for the reasonable value of any services and Benefits we provided to you. We may receive reimbursement for the total amount of past Benefits paid, not to exceed the amount you receive from any third party as described below:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including:
 - Providing any relevant information requested by us.
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.

- If we incur attorneys' fees and costs in order to collect from third party settlement funds held by you or your representative, we have the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to us.
- That you agree that if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, as stated herein, separately and alone, and failure to hold funds as such will be deemed by us to be a breach of contract, and may result in the instigation of legal action against you.
- That you will not do anything to prejudice our rights under this provision. Our rights to recovery will not be reduced due to your own negligence.
- That you will assign to us all rights of recovery against Third Parties, to the extent of the reasonable value of services and Benefits we provided.
- That our rights will be considered as the first priority claim against Third Parties, including tortfeasors from whom you are seeking recovery, to be paid before any other of your claims are paid.
- That we may, at our option, take necessary and appropriate action to preserve our rights under these subrogation provisions, including providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party filing suit in your name, which does not obligate us in any way to pay you part of any recovery we might obtain.
- That you may not accept any settlement that does not fully reimburse us, without our written approval.
- That we have the authority to resolve all disputes regarding the interpretation of the language stated in this provision.
- That we shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That no allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse us for 100% of our interests unless we provide written consent to the allocation.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- That if a third party causes you to suffer a Sickness or Injury while you are covered under this Policy, provisions of this section continue to apply, even after you are no longer covered.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.

- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the refund is due from the Covered Person and the Covered Person does not promptly refund the full amount, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, future Benefits for the Covered Person that are payable under the Policy. If the refund is due from a person or organization other than the Covered Person, we may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part; (i) future Benefits that are payable in connection with services provided to other Covered Persons under the Policy; or (ii) future Benefits that are payment in connection with services provided to persons under other plans for which we make payments, pursuant to a transaction in which our overpayment recovery rights are assigned to such other plans in exchange for such plans' remittance of the amount of the reallocated payment.

The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until you have completed all the steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*. After completing that process, if you want to bring a legal action against us you must do so within three years of the date we notified you of our final decision on your appeal or you lose any rights to bring such an action against us.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Adverse Determination - a determination by a utilization review agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational.

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis, and includes a Crisis Stabilization Unit, a Psychiatric Day Treatment Facility, a Mental Health Center, and a Residential Treatment Center for Children and Adolescents.

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Assisted Living Facility - a facility regulated by Chapter 247 of the Health and Safety Code.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

Chemical Dependency - the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance. For the purposes of this definition, "controlled substance" means an abusable volatile chemical, as defined by Section 485.001, Health and Safety Code, or a substance designated as a controlled substance under Chapter 481, Health and Safety Code.

Coinurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Complications of Pregnancy - conditions requiring hospital confinement (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis, gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and non-elective cesarean section, termination of ectopic pregnancy and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Crisis Stabilization Unit - a 24-hour residential program that is usually short-term in nature and that provides intensive supervision and highly structure activities to persons who are demonstrating an acute demonstrable psychiatric crisis of moderate to severe proportions.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Subscriber's legal spouse including common law spouse or a child of the Subscriber or the Subscriber's spouse. All references to the spouse of a Subscriber shall include a Domestic Partner, except for the purpose of coordinating Benefits with Medicare. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for who the Subscriber is a party in a suit seeking adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

The marital status or lack of marital status between the Subscriber and the other parent will not be a factor in determining a Dependent's eligibility.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child of any age who is or becomes disabled and dependent upon the Subscriber.
- A Dependent includes a grandchild of the Subscriber, who is under 26 years of age and is a Dependent of the Subscriber for federal income tax purposes at the time the application for coverage of the grandchild is made.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Services via interactive audio and video modalities.

Domestic Partner - a person of the opposite or same sex with whom the Subscriber has established a Domestic Partnership.

Domestic Partnership - a relationship between a Subscriber and one other person of the opposite or same sex. All of the following requirements apply to both persons:

- They must not be related by blood or a degree of closeness that would prohibit marriage in the law of the state in which they reside.
- They must not be currently married to, or a Domestic Partner of, another person under either statutory or common law.
- They must share the same permanent residence and the common necessities of life.

- They must be at least 18 years of age.
- They must be mentally competent to consent to contract.
- They must be financially interdependent.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the United States.

Emergency - health care services provided in a Hospital, emergency facility, Freestanding Emergency Medical Care Facility, or comparable emergency facility to evaluate and stabilize a medical condition of recent onset or severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing the person's health in serious jeopardy.
- Serious impairment of bodily functions.
- Serious dysfunction of a bodily organ or part.
- Serious disfigurement.
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Health Services - with respect to an Emergency:

- A medical screening examination (as required under section 1867 of the *Social Security Act*, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency, and
- Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the *Social Security Act* (42 U.S.C. 1395dd(e)(3)).

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Drugs prescribed to treat a chronic, disabling, or life-threatening illness if the drug is both of the following:
 - Has been approved by the *FDA* for at least one indication.
 - Is recognized for treatment of the indication for which the drug is prescribed in either of the following:
 - ♦ A prescription drug reference compendium approved by the *Commissioner of the Texas Department of Insurance*.
 - ♦ Substantially accepted peer-reviewed medical literature.
- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Freestanding Emergency Medical Care Facility - a facility, structurally separate and distinct from a Hospital that receives an individual and provides Emergency care.

Freestanding Facility - an outpatient, diagnostic or ambulatory center or independent laboratory which performs services and submits claims separately from a Hospital.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Hospital-based Facility - an outpatient facility that performs services and submits claims as part of a Hospital.

Independent Review Organization (IRO) - an organization certified by the State of Texas to hear appeals of Adverse Determinations.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Behavioral Therapy (IBT) - outpatient behavioral/educational services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age appropriate skills in people with Autism Spectrum Disorders. Examples include *Applied Behavioral Analysis (ABA)*, *The Denver Model*, and *Relationship Development Intervention (RDI)*.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be freestanding or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as decided by us or our designee.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be made solely by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Center - a tax supported institution of the State of Texas, including community centers for mental health and mental retardation services.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Clinical Benefit Determination - a determination made by us that proposed or delivered services are or are not covered services according to the terms of the insurance Policy without reference to the medical necessity or appropriateness of the services. A Non-clinical Benefit Determination that services are not covered is not an Adverse Determination.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a freestanding or Hospital-based program and that provides services for at least 20 hours per week.

Pharmaceutical Product(s) - *U.S. Food and Drug Administration (FDA)*-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Pharmaceutical Product List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. We will not remove Pharmaceutical Products from our Pharmaceutical Product List nor change the placement of a Pharmaceutical Product among the tiers more often than annually on the Policy anniversary date. You may determine to which tier a particular Pharmaceutical Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any acupuncturist, advanced practice nurse, audiologist, chemical dependency counselor, dietitian, hearing instrument fitter and dispenser, licensed clinical social worker, licensed professional counselor, marriage and family therapist, occupational therapist, physical therapist, Physician, physician assistant, psychological associate, speech language pathologies, surgical assistant, podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.

- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Psychiatric Day Treatment Facility - a mental health facility that provides treatment for individuals suffering from acute mental and nervous disorders in a structured psychiatric program, utilizing individualized treatment plans with specific attainable goals and objectives that are appropriate both to the patient and to the treatment modality of the program. The facility must be clinically supervised by a *Doctor of Medicine* who is certified in psychiatry by the *American Board of Psychiatry and Neurology*.

Residential Treatment - treatment in a facility which provides Mental Health Services or Substance Use Disorder Services treatment. The facility meets all of the following requirements:

- It is established and operated in accordance with applicable state law for Residential Treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by us.

- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment facility that qualifies as a Hospital is considered a Hospital.

Residential Treatment Center for Children and Adolescents - a child-care institution that is both of the following:

- Provides residential care and treatment for emotionally disturbed children and adolescents.
- Accredited as a residential treatment center by any of these:
 - *The Council of Accreditation.*
 - *The Joint Commission on Accreditation of Hospitals.*
 - *The American Association of Psychiatric Services for Children.*

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Note that Benefits for Outpatient Prescription Drugs and Gender Dysphoria Treatment, while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under the Policy. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Serious Mental Illness - the following psychiatric illnesses as defined in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- Schizophrenia.
- Paranoid and other psychotic disorders.
- Bipolar disorders (hypomanic, manic, depressive, and mixed).
- Major depressive disorders (single episode or recurrent).
- Schizo-affective disorders (bipolar or depressive).
- Obsessive-compulsive disorders.
- Depression in childhood and adolescence.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* includes Mental Illness or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Living - Mental health services and substance use disorder services that are provided through facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products - Outpatient* in your *Certificate of Coverage*, regardless of tier placement.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.

- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Non-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject to our periodic review and modification. There may be certain Prescription Drug Products that require you to notify us directly rather than your Physician or pharmacist. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance, and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

- Certain coupons or offers from pharmaceutical manufacturers. You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.
- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
<p>Copayment</p> <p>Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount.</p> <p>Coinsurance</p> <p>Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p>Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.</p> <p>Copayment and Coinsurance</p> <p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.</p> <p>We may cover multiple Prescription Drug Products for a single Copayment and/or Coinsurance if the combination of these multiple products provides a therapeutic treatment regimen that is supported by available clinical evidence. You may determine whether a therapeutic treatment regimen qualifies for a single Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lowest of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. • The Prescription Drug Charge for that Prescription Drug Product. <p>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. <p>See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.</p>

Payment Term And Description	Amounts
<p>www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Copayment/Coinsurance Waiver Program: If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.</p> <p>Prescription Drug Products Prescribed by a Specialist Physician: You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>NOTE: We may periodically change the placement of a Prescription Drug Product among the tiers or remove a Prescription Drug Product from our Prescription Drug List, based on the Prescription Drug List (PDL) Management Committee's periodic review and decisions. These changes will occur no more often than annually on the Policy anniversary date. When</p>	

Payment Term And Description	Amounts
<p>that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.</p> <p>Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p>	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
<p>Specialty Prescription Drug Products</p> <p>The following supply limits apply.</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>If a Specialty Prescription Drug Product is provided for less than or more than a 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$15.00 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$40.00 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$75.00 per Prescription Order or Refill.</p> <p>Non-Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$15.00 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$40.00 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$75.00 per Prescription Order or Refill.</p>
<p>Prescription Drugs from a Retail Network Pharmacy</p> <p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. This includes contraceptive devices and outpatient contraceptive 	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier 1 Prescription Drug Product: 100% of the</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>services other than oral contraceptives, which are described below.</p> <ul style="list-style-type: none"> A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p>	<p>Prescription Drug Charge after you pay a Copayment of \$15.00 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$40.00 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$75.00 per Prescription Order or Refill.</p>
Prescription Drugs from a Retail Non-Network Pharmacy	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. This includes contraceptive devices and outpatient contraceptive services other than oral contraceptives, which are described below. A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$15.00 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$40.00 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$75.00 per Prescription Order or Refill.</p>
Prescription Drug Products from a Mail Order Network Pharmacy	
The following supply limits apply:	Your Copayment and/or Coinsurance is determined by the

Description and Supply Limits	Benefit (The Amount We Pay)
<ul style="list-style-type: none"> As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>. <p>We may allow a 31 day fill at the Mail Order Pharmacy for certain Prescription Drug Products for the Copayment and/or Coinsurance you would pay at a retail Network Pharmacy. You may determine whether a 31 day fill of Prescription Drug Product is available through the Mail Order Pharmacy for a retail Network Pharmacy Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>You may be required to fill an initial Prescription Drug Product order and obtain 2 refills through a retail pharmacy prior to using a mail order Network Pharmacy.</p> <p>To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.</p>	<p>tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2 or Tier 3. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For up to a 90-day supply, we pay:</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$37.50 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$100.00 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$187.50 per Prescription Order or Refill.</p>

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.

UNITEDHEALTHCARE INSURANCE COMPANY

A handwritten signature in black ink, appearing to read 'Jeffrey Alter', with a stylized flourish at the end.

Jeffrey Alter, President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed.

We may periodically change the placement of a Prescription Drug Product among the tiers or remove a Prescription Drug Product from our Prescription Drug List. These changes will occur no more often than annually on the Policy anniversary date. We will provide a 60-day written notice prior to the effective date of any change. Please call the number on the back of your ID card to determine whether a specific drug is included under the drug formulary.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Continuation of Prescription Drug Coverage

We will continue to provide Network Benefits for any Prescription Drug Product that has been approved or covered under the Policy for a medical condition or Mental Illness, regardless of whether the drug has been removed from the Prescription Drug List before the Policy renewal date. Your Physician or other health care provider with authorization to prescribe a drug may prescribe an alternative drug if the Prescription Drug Product is covered under the Policy and if it is medically appropriate for the Covered Person.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the

Prescription Drug Charge, less the required Copayment and/or Coinsurance and any deductible that applies.

Submit your claim to the Pharmacy Benefit Manager claims address noted on your ID card.

Specialty Pharmacy Program

If you require certain Specialty Prescription Drug Products, we may direct you to pharmacies with whom we have an arrangement to provide Specialty Prescription Drug Products.

If you are directed to such pharmacies and you choose not to obtain your Specialty Prescription Drug Product from one of these pharmacies, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.

Smart Fill Program - Split Fill

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 15-day supplies up to 90 days and at a pro-rated Copayment or Coinsurance. The Covered Person will receive a 15-day supply of their Specialty Prescription Drug Product to determine if they will tolerate the Specialty Prescription Drug Product prior to purchasing a full supply. The Designated Pharmacy will contact the Covered Person each time prior to dispensing the 15-day supply to confirm if the Covered Person is tolerating the Specialty Prescription Drug Product. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Smart Fill Program - 90 Day Supply

Certain Specialty Prescription Drug Products may be dispensed by the Designated Pharmacy in 90-day supplies. The Copayment and/or Coinsurance will reflect the number of days dispensed. The *Smart Fill Program* which offers a 90 day supply of certain Specialty Prescription Drug Products is for a Covered Person who is stabilized on a Specialty Prescription Drug Product included in the *Smart Fill Program*. You may find a list of Specialty Prescription Drug Products included in the *Smart Fill Program*, through the internet www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List. We do not pass these rebates on to you, nor are they taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. In some instances, non-UnitedHealthcare entities may support and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, we may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications. If you choose not to obtain your Maintenance Medications from the Mail Order Network Pharmacy, you may opt-out of the Maintenance Medication Program through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card. If you choose to opt out of Mail Order Network Pharmacy but do not inform us, you will be subject to the non-Network Benefit for that Prescription Drug Product after the allowed number of fills at Retail Network Pharmacy.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Required Prescription Drug Coverage

Benefits are available for any Prescription Drug Product prescribed to treat a Covered Person for a chronic, disabling, or life-threatening illness that is a Covered Health Service if:

- The Prescription Drug Product has been approved by the *United States Food and Drug Administration* for at least one indication; and
- The Prescription Drug Product is recognized by the following for treatment of the indication for which the drug is prescribed:
 - A prescription drug reference compendium approved by the commissioner for purposes of this section; or
 - A substantially accepted peer-reviewed medical literature.
- Benefits for the Prescription Drug Product required above will include coverage for Medically Necessary services associated with the administration of the drug.
- Benefits will not be denied for a Prescription Drug Product based on medical necessity, unless the reason for denial is unrelated to the legal status of the drug use.
- Benefits will not be provided for the following:
 - Experimental drugs that are not otherwise approved for an indication by the *United States Food and Drug Administration*;
 - Any disease or condition that is an exclusion under this plan.
 - A drug that the *United States Food and Drug Administration* has determined to be contraindicated for treatment of the current indication.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* also apply to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will not apply to drugs prescribed to treat a chronic, disabling, or life-threatening illness if the drug is both of the following:
 - Has been approved by the *U.S. Food and Drug Administration (FDA)* for at least one indication.
 - Is recognized for treatment of the indication for which the drug is prescribed in either of the following:
 - ♦ A prescription drug reference compendium approved by the *Commissioner* of the *Texas Department of Insurance*.
 - ♦ Substantially accepted peer-reviewed medical literature.
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression or weight loss.
9. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment, including insulin pumps and related supplies for the management and treatment of diabetes, for which Benefits are provided in your *Certificate*. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging or repackagers of Prescription Drug Products.

13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Certain Prescription Drug Products for smoking cessation.
18. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that contain a non-*FDA* approved bulk chemical. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 3.)
19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations will occur no more often than annually on the Policy anniversary date, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter items for which Benefits are provided as described in the *Certificate* under *Diabetes Services* in *Section 1: Covered Health Services*. This exclusion does not apply to over-the-counter drugs used for smoking cessation.
20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury. This exclusion does not apply to:
 - Nutritional supplements for the treatment of Autism Spectrum Disorders, as described in *Section 1: Covered Health Services* of the *Certificate*, which meet the definition of a Covered Health Service.
 - Amino acid-based elemental formulas as described under *Amino Acid-Based Elemental Formulas* in *Section 1: Covered Health Services* of the *Certificate*.
 - Formulas for phenylketonuria (PKU) or other heritable diseases.
23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations will occur no more often than annually on the Policy anniversary date, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
24. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations will occur no more often than annually on the Policy anniversary date, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.

25. Certain Prescription Drug Products for which there are Therapeutically Equivalent alternatives available, unless otherwise required by law or approved by us. Such determinations will occur no more often than annually on the Policy anniversary date, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
26. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
27. A Prescription Drug Product that contains marijuana, including medical marijuana.
28. Dental products, including but not limited to prescription fluoride topicals.
29. A Prescription Drug Product with an approved biosimilar or a biosimilar and Therapeutically Equivalent to another covered Prescription Drug Product. For the purpose of this exclusion a "biosimilar" is a biological Prescription Drug Product approved based on showing that it is highly similar to a reference product (a biological Prescription Drug Product) and has no clinically meaningful differences in terms of safety and effectiveness from the reference product. Such determinations will occur no more often than annually on the Policy anniversary date, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
30. Diagnostic kits and products.
31. Publicly available software applications and/or monitors that may be available with or without a Prescription Order or Refill.

Section 3: Defined Terms

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, data sources such as Medi-Span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, data sources such as Medi-Span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Maintenance Medication - a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications or products that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification. These changes will occur no more often than annually on the Policy anniversary date. You

may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication or product that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices; and
 - glucose monitors. This does not include continuous glucose monitors.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Gender Dysphoria Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for the treatment of Gender Dysphoria.

Because this Rider is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Rider below.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

Section 1: Covered Health Services

The following provision is added to the Certificate, Section 1: Covered Health Services:

Gender Dysphoria

Benefits for the treatment of Gender Dysphoria are limited to the following services:

- Psychotherapy for Gender Dysphoria and associated co-morbid psychiatric diagnoses are provided as described under *Mental Health Services* in your *Certificate*.
- Cross-sex hormone therapy:
 - Cross-sex hormone therapy administered by a medical provider (for example during an office visit) is described under *Pharmaceutical Products - Outpatient* in your *Certificate*.
 - Cross-sex hormone therapy dispensed from a pharmacy is provided as described in the *Outpatient Prescription Drug Rider*.
 - Puberty suppressing medication is not cross-sex hormone therapy.
- Laboratory testing to monitor the safety of continuous cross-sex hormone therapy.
- Surgery for the treatment of Gender Dysphoria, including the surgeries listed below.

Male to Female:

- Clitoroplasty (creation of clitoris)
- Labiaplasty (creation of labia)
- Orchiectomy (removal of testicles)
- Penectomy (removal of penis)
- Urethroplasty (reconstruction of female urethra)
- Vaginoplasty (creation of vagina)

Female to Male:

- Bilateral mastectomy or breast reduction

- Hysterectomy (removal of uterus)
- Metoidioplasty (creation of penis, using clitoris)
- Penile prosthesis
- Phalloplasty (creation of penis)
- Salpingo-oophorectomy (removal of fallopian tubes and ovaries)
- Scrotoplasty (creation of scrotum)
- Testicular prosthesis
- Urethroplasty (reconstruction of male urethra)
- Vaginectomy (removal of vagina)
- Vulvectomy (removal of vulva)

Genital Surgery and Bilateral Mastectomy or Breast Reduction Surgery Documentation Requirements:

The Covered Person must provide documentation of the following for breast surgery:

- A written psychological assessment from at least one qualified behavioral health provider experienced in treating Gender Dysphoria. The assessment must document that the Covered Person meets all of the following criteria:
 - Persistent, well-documented Gender Dysphoria.
 - Capacity to make a fully informed decision and to consent for treatment.
 - Must be 18 years or older.
 - If significant medical or mental health concerns are present, they must be reasonably well controlled.

The Covered Person must provide documentation of the following for genital surgery:

- A written psychological assessment from at least two qualified behavioral health providers experienced in treating Gender Dysphoria, who have independently assessed the Covered Person. The assessment must document that the Covered Person meets all of the following criteria.
 - Persistent, well-documented Gender Dysphoria.
 - Capacity to make a fully informed decision and to consent for treatment.
 - Must 18 years or older.
 - If significant medical or mental health concerns are present, they must be reasonably well controlled.
 - Complete at least 12 months of successful continuous full-time real-life experience in the desired gender.
 - Complete 12 months of continuous cross-sex hormone therapy appropriate for the desired gender (unless medically contraindicated).

Schedule of Benefits

The provision below for Gender Dysphoria is added to the Schedule of Benefits and the following bulleted item is added to the Schedule of Benefits as a Covered Health Service which requires prior authorization under Covered Health Services which Require Prior Authorization:

- Gender Dysphoria treatment.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Gender Dysphoria	<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization as soon as the possibility for any of the services listed above for Gender Dysphoria treatment arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses, however the reduction in Benefits will not exceed \$500.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for an Inpatient Stay.</p>		
	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug Rider</i>.</p> <p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in the <i>Schedule of Benefits</i> and in the <i>Outpatient Prescription Drug Rider</i>.</p>		

Section 2: Exclusions and Limitations

The exclusion for sex transformation operations and related services in the Certificate under Section 2: Exclusions and Limitations, Procedures and Treatments is deleted. In addition, the following exclusions apply:

- Cosmetic Procedures, including the following:
 - Abdominoplasty
 - Blepharoplasty
 - Breast enlargement, including augmentation mammoplasty and breast implants
 - Body contouring, such as lipoplasty
 - Brow lift
 - Calf implants

- Cheek, chin, and nose implants
- Injection of fillers or neurotoxins
- Face lift, forehead lift, or neck tightening
- Facial bone remodeling for facial feminizations
- Hair removal
- Hair transplantation
- Lip augmentation
- Lip reduction
- Liposuction
- Mastopexy
- Pectoral implants for chest masculinization
- Rhinoplasty
- Skin resurfacing
- Thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave (removal or reduction of the Adam's Apple)
- Voice modification surgery
- Voice lessons and voice therapy

Section 9: Defined Terms

The following definition of Gender Dysphoria is added to the Certificate under Section 9: Defined Terms:

Gender Dysphoria - a disorder characterized by the following diagnostic criteria classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*:

- *Diagnostic criteria for adults and adolescents:*
 - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least two of the following:
 - ♦ A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
 - ♦ A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
 - ♦ A strong desire for the primary and/or secondary sex characteristics of the other gender.
 - ♦ A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
 - ♦ A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).

- ♦ A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- The condition is associated with clinically significant distress or impairment in social, occupational or other important areas of functioning.
- *Diagnostic criteria for children:*
 - A marked incongruence between one's experienced/expressed gender and assigned gender, of at least six months' duration, as manifested by at least six of the following (one of which must be criterion as shown in the first bullet below):
 - ♦ A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
 - ♦ In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
 - ♦ A strong preference for cross-gender roles in make-believe play or fantasy play.
 - ♦ A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
 - ♦ A strong preference for playmates of the other gender.
 - ♦ In boys (assigned gender), a strong rejection of typically masculine toys, games and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games and activities.
 - ♦ A strong dislike of one's sexual anatomy.
 - ♦ A strong desire for the primary and/or secondary sex characteristics that match one's experienced gender.
 - The condition is associated with clinically significant distress or impairment in social, school or other important areas of functioning.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

Real Appeal Rider

UnitedHealthcare Insurance Company

This Rider to the Policy provides Benefits for virtual obesity counseling services for eligible Covered Persons through Real Appeal. There are no deductibles, Copayments or Coinsurance you must meet or pay for when receiving these services.

Real Appeal

Benefits are provided for Real Appeal, which provides a virtual lifestyle intervention for weight-related conditions to eligible Covered Persons. The goal is to help those at risk from obesity-related diseases. Real Appeal is designed to support Covered Persons 18 years of age or older.

This intensive, multi-component behavioral intervention provides 52 weeks of support. This support includes one-on-one coaching and online group participation with supporting video content, delivered by a live virtual coach. The experience will be personalized for each individual through an introductory online session.

These Covered Health Services will be individualized and may include, but are not limited to, the following:

- Virtual support and self-help tools: Personal one-on-one coaching, group support sessions, educational videos, tailored kits, integrated web platform and mobile applications.
- Education and training materials focused on goal setting, problem-solving skills, barriers and strategies to maintain changes.
- Behavioral change counseling by a specially trained coach for clinical weight loss.

If you would like additional information regarding these Covered Health Services, you may contact us through www.realappeal.com, <https://member.realappeal.com> or *Customer Care* at the number shown on your ID card.

UNITEDHEALTHCARE INSURANCE COMPANY



Jeffrey Alter, President

Language Assistance Services

We¹ provide free language services to help you communicate with us. We offer interpreters, letters in other languages, and letters in other formats like large print. To get help, please call 1-866-633-2446, or the toll-free member phone number listed on your health plan ID card, TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m. ET.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al 1-866-633-2446.

請注意：如果您說中文 (**Chinese**)，我們免費為您提供語言協助服務。請致電：1-866-633-2446。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi 1-866-633-2446.

알림: 한국어(**Korean**)를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-633-2446 번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa 1-866-633-2446.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **Русский (Russian)**. Позвоните по номеру 1-866-633-2446.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال بـ 1-866-633-2446.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan 1-866-633-2446.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le 1-866-633-2446.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer 1-866-633-2446.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para 1-866-633-2446.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero 1-866-633-2446.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie 1-866-633-2446 an.

注意事項：日本語 (**Japanese**) を話される場合、無料の言語支援サービスをご利用いただけます。1-866-633-2446 にお電話ください。

توجه: اگر زبان شما فارسی (**Farsi**) است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد.
1-866-633-2446 تماس بگیرید.

कृपा ध्यान दें: यदि आप **हिंदी (Hindi)** भाषी हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। कृपा पर काल करें 1-866-633-2446

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau 1-866-633-2446.

ចំណាប់អារម្មណ៍: បើសិនម្នាក់និយាយ**ភាសាខ្មែរ(Khmer)**សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់ម្នាក់។ សូមទូរស័ព្ទ ទៅលេខ 1-866-633-2446។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti 1-866-633-2446.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yánilti'go, saad bee áka'anída'awo'ígíí, t'áá jíí'eh, bee ná'ahóót'i'. T'áá shoodí kohjì' 1-866-633-2446 hodiilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac 1-866-633-2446.

Notice of Non-Discrimination

We¹ do not treat members differently because of sex, age, race, color, disability or national origin.

If you think you were treated unfairly because of your sex, age, race, color, disability or national origin, you can send a complaint to:

Civil Rights Coordinator
UnitedHealthcare Civil Rights Grievance
P.O. Box 30608
Salt Lake City, UT 84130
UHC_Civil_Rights@uhc.com

You must send the complaint within 60 days of the incident. We will send you a decision within 30 days. If you disagree with the decision, you have 15 days to appeal.

If you need help with your complaint, please call 1-866-633-2446 or the toll-free member phone number listed on your health plan ID card, TTY 711. We are available Monday through Friday, 8 a.m. to 8 p.m.

You can also file a complaint with the U.S. Dept. of Health and Human services.

Online: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Phone: Toll-free 1-800-368-1019, 1-800-537-7697 (TDD)

Mail: U.S. Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

¹For purposes of the Language Assistance Services and this Non-Discrimination Notice ("Notice"), "we" refers to the entities listed in Footnote 2 of the Notice of Privacy Practices and Footnote 3 of the Financial Information Privacy Notice. Please note that not all entities listed are covered by this Notice.

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Certificate of Coverage (Certificate)* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below. These changes will apply to any "non-grandfathered" plan. Contact your Plan Administrator to determine whether or not your plan is a "grandfathered" or a "non-grandfathered plan". Under the *Patient Protection and Affordable Care Act (PPACA)* a plan generally is "grandfathered" if it was in effect on March 23, 2010 and there are no substantial changes in the benefit design as described in the *Interim Final Rule on Grandfathered Health Plans* at that time.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. Essential benefits include the following:

Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.
- Essential benefits for plan years beginning prior to January 1, 2014 can only be subject to restricted annual limits. Restricted annual limits for each person covered under the plan may be no less than the following:
 - For plan or policy years beginning on or after September 23, 2010 but before September 23, 2011, \$750,000.
 - For plan or policy years beginning on or after September 23, 2011 but before September 23, 2012, \$1,250,000.
 - For plan or policy years beginning on or after September 23, 2012 but before January 1, 2014, \$2,000,000.

Please note that for plan years beginning on or after January 1, 2014, essential health benefits cannot be subject to annual or lifetime dollar limits.

- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday. If you have a grandfathered plan, the enrolling group is not required to extend coverage to age 26 if the child is eligible to enroll in an eligible employer-sponsored health plan (as defined by law).

On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26.

During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or injury.

- If you do not have a grandfathered plan, in-network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:
 - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
 - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
 - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
 - With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
- Retroactive rescission of coverage under the policy is permitted, with 30 days advance written notice, only in the following two circumstances:
 - The individual performs an act, practice or omission that constitutes fraud.
 - The individual makes an intentional misrepresentation of a material fact.
- Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
 - Direct access to OB/GYN care without a referral or authorization requirement.
 - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
 - Prior authorization is not required before you receive services in the emergency department of a hospital.

If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Effective for policies that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials. This modification is optional for certain grandfathered health plans. Refer to your plan documents to determine if this modification has been made to your plan.

Pre-Existing Conditions:

Any pre-existing condition exclusions (including denial of benefit or coverage) will not apply to covered persons regardless of age.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or UnitedHealthcare for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call UnitedHealthcare at the number listed on your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, they will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact UnitedHealthcare at the number listed on your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you. A list of states with Consumer Assistance Programs is available at: www.dol.gov/ebsa/healthreform and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants>.

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

If your plan includes coverage for Mental Health or Substance Use, the following applies:

Mental Health/Substance Use Disorder Parity

Effective for non-grandfathered small group Policies that are new or renewing on or after January 1, 2014, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Effective for grandfathered small group Policies that are new or renewing on or after July 1, 2010, Benefits for mental health conditions and substance use conditions that are Covered Health Services under the Policy will be revised to align prior authorization requirements and excluded services listed in your *Certificate* with Benefits for other medical conditions.

Effective for grandfathered and non-grandfathered large group Policies that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the *Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)*. Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. *MHPAEA* requires specific testing to be

applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information through the submission of your appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018:

We² are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically, in accordance with applicable law. In all cases, if we maintain a website for your particular health plan, we will post the revised notice on your health plan website, such as www.myuhc.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollees' information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.

- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services. We may also de-identify health information in accordance with applicable laws. After that information is de-identified, the information is no longer subject to this notice and we may use the information for any lawful purpose.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration purposes if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.
- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets federal privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, and pursuant to federal law, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract and as permitted by federal law.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
 1. HIV/AIDS;
 2. Mental health;
 3. Genetic tests;
 4. Alcohol and drug abuse;
 5. Sexually transmitted diseases and reproductive health information; and
 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on your health plan ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however; we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases, you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on your health plan ID card or you may contact the *UnitedHealth Group Customer Call Center* Representative at 1-866-633-2446 or TTY 711.
- **Submitting a Written Request.** You can mail your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, to us at the following address:

UnitedHealthcare
Customer Service - Privacy Unit
PO Box 740815
Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

²*This Medical Information Notice of Privacy Practices applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Optum Insurance Company of Ohio, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of Texas, LLC; Preferred Care Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; Rocky Mountain Health Maintenance Organization, Incorporated; Rocky Mountain Health Management Corporation; Rocky Mountain HealthCare Options, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan of Georgia, Inc.; UnitedHealthcare Community Plan of Ohio, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.*

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY.

Effective January 1, 2018

We³ are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

Depending upon the product or service you have with us, we may collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from a consumer reporting agency.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on your health plan ID card or contact the *UnitedHealth Group Customer Call Center* at 1-866-633-2446 or TTY 711.

³For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 2, beginning on the first page of the Health Plan Notices of Privacy Practices, plus the following UnitedHealthcare affiliates: Alere Women's and Children's Health, LLC; AmeriChoice Health Services,

Inc.; CNIC Health Solutions, Inc.; Connexions HCI, LLC; LifePrint East, Inc.; Life Print Health, Inc.; Dental Benefit Providers, Inc.; gethealthinsurance.com Agency, Inc.; Golden Outlook, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; OptumHealth Care Solutions, Inc.; OrthoNet, LLC; OrthoNet of the Mid-Atlantic, Inc.; OrthoNet West, LLC; OrthoNet of the South, Inc.; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; POMCO Network, Inc.; POMCO of Florida, Ltd.; POMCO West, Inc.; POMCO, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UNITEDHEALTH GROUP**HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS**

Revised: January 1, 2018

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

1. show the categories of health information that are subject to these more restrictive laws; and
2. give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information	
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.	
Genetic Information	
We are not allowed to use genetic information for underwriting purposes.	

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AR, CA, DE, NE, NY, PR, RI, UT, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	KY, MO, NJ, SD
We must comply with additional restrictions prior to using or disclosing your health information for certain purposes.	KS
Prescriptions	

We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and /or (2) to specific recipients.	ID, NH, NV
Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and /or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AR, CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, ME, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
We will collect certain HIV/AIDS-related information only with your written consent.	OR
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual	WA

who is the subject of the information.	
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME
Child or Adult Abuse	
We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	AL, AR, CO, IL, LA, MD, NE, NJ, NM, NY, RI, TN, TX, UT, WI

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If

you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under *ERISA*, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

ERISA Statement

If the Enrolling Group is subject to *ERISA*, the following information applies to you.

Summary Plan Description

Name of Plan: TriStar Global Energy Solutions, Inc. Welfare Benefit Plan

Name, Address and Telephone Number of Plan Sponsor and Named Fiduciary:

TriStar Global Energy Solutions, Inc.
12600 N. Featherwood, Ste 330
Houston, TX 77034
(832) 775-1586

The Plan Sponsor retains all fiduciary responsibilities with respect to the Plan, except to the extent the Plan Sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities with respect to the Plan.

Claims Fiduciary: UnitedHealthcare Insurance Company ("UnitedHealthcare," refer to your Certificate of Coverage for details on the legal entity that provides your coverage) is your Plan's Claims Fiduciary and has been delegated this responsibility by your Plan Sponsor. Your Claims Fiduciary has the authority to require eligible individuals to furnish it with information necessary for the proper administration of your Plan.

Employer Identification Number (EIN): 20-3884168

Plan Number: 501

Plan Year: April 1 through March 31

Type of Plan: Health care coverage plan

Name, Business Address, and Business Telephone Number of Plan Administrator:

TriStar Global Energy Solutions, Inc.
12600 N. Featherwood, Ste 330
Houston, TX 77034
(832) 775-1586

Type of Administration of the Plan: Your Plan is fully insured. Benefits are provided under a group insurance contract entered into between your Plan Sponsor and UnitedHealthcare. Claims for benefits are sent to UnitedHealthcare. Your employer and UnitedHealthcare share responsibility for administering the plan.

UnitedHealthcare
185 Asylum Street
Hartford, CT 06103-0450
860-702-5000

Person designated as Agent for Service of Legal Process: Plan Administrator

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries: The Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given deference and be legally binding on all parties and subject to review by a legal authority only to the extent the decision was arbitrary and capricious.

Source of Contributions and Funding under the Plan: There are no contributions to the Plan. Any required employee contributions are used to partially reimburse the Plan Sponsor for Premiums under the Plan. Benefits under the Plan are funded by the payment of Premium required by the group Policy.

Method of Calculating the Amount of Contribution: Employee-required contributions to the Plan Sponsor are the employee's share of costs as determined by Plan Sponsor. From time to time, the Plan Sponsor will determine the required employee contributions for reimbursement to the Plan Sponsor and distribute a schedule of such required contributions to employees.

Qualified Medical Child Support Orders: The Plan's procedures for handling qualified medical child support orders are available without charge upon request to the Plan Administrator.

Amendment or Termination of the Plan: Your employer, as the Plan Sponsor, has the right to amend or terminate this Plan at any time. Note that the insurance contract, which is how benefits under the Plan are provided, is not necessarily the same as the Plan. As a result, termination of the insurance contract does not necessarily terminate the Plan.

EXHIBIT D



UnitedHealthcare
185 Asylum Street
Cityplace I
Hartford, CT 06103

October 13, 2015

G/GA5U2205NM

GANDY CORPORATION
1623 S MAIN
LOVINGTON, NM 882600000

Dear Customer:

Enclosed in this package are your Group coverage documents. Depending on the type(s) of coverage you have selected there may be one or more sets of Master Documents. Please keep all Master Documents and any applicable amendment(s) with your other coverage records.

Please distribute one copy of the coverage document(s) to each of your covered Employees.

For your convenience, you no longer need to order document(s) for new hires. As future Employees become covered, you will be sent a copy of the document(s) for each new employee. If an employee has misplaced their coverage document(s), please continue to call the Customer Service Center.

If you have any questions about this information, please contact your UnitedHealthcare Customer Service Center at the number on the back of your ID card.

Very truly yours,

A handwritten signature in black ink that reads 'Christopher Hock'. The signature is fluid and cursive, with the first and last names being clearly legible.

Christopher Hock
Broker & Employee Operations
UnitedHealthcare

UnitedHealthcare Insurance Company

Group Policy For GANDY CORPORATION

UnitedHealthcare Choice Plus

Group Number: G/GA5U2205NM **Health Plan:** YE - V **Prescription Code:** 5Y
Effective Date: April 1, 2015

Group Policy

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

1-800-357-1371

This Policy is entered into by and between UnitedHealthcare Insurance Company and the "Enrolling Group," as described in Exhibit 1.

When used in this document, the words "we," "us," and "our" are referring to UnitedHealthcare Insurance Company.

Upon our receipt of the Enrolling Group's signed application and payment of the first Policy Charge, this Policy is deemed executed.

We agree to provide Benefits for Covered Health Services set forth in this Policy, including the attached *Certificate(s) of Coverage* and *Schedule(s) of Benefits*, subject to the terms, conditions, exclusions, and limitations of this Policy. The Enrolling Group's application is made a part of this Policy.

This Policy replaces and overrules any previous agreements relating to Benefits for Covered Health Services between the Enrolling Group and us. The terms and conditions of this Policy will in turn be overruled by those of any subsequent agreements relating to Benefits for Covered Health Services between the Enrolling Group and us.

We will not be deemed or construed as an employer or plan administrator for any purpose with respect to the administration or provision of benefits under the Enrolling Group's benefit plan. We are not responsible for fulfilling any duties or obligations of an employer or plan administrator with respect to the Enrolling Group's benefit plan.

This Policy will become effective on the date specified in Exhibit 1 and will be continued in force by the timely payment of the required Policy Charges when due, subject to termination of this Policy as provided in Article 5.

When this Policy is terminated, as described in Article 5, this Policy and all Benefits under this Policy will end at 12:00 midnight on the date of termination.

This Policy is issued as described in Exhibit 1.

Issued By:

UnitedHealthcare Insurance Company



President

Article 1: Glossary of Defined Terms

The terms used in this Policy have the same meanings given to those terms in *Section 9: Defined Terms* of the attached *Certificate(s) of Coverage*.

Coverage Classification - one of the categories of coverage described in Exhibit 2 for rating purposes (for example: Subscriber only, Subscriber and spouse, Subscriber and children, Subscriber and family).

Material Misrepresentation - any oral or written communication or conduct, or combination of communication and conduct, that is untrue and is intended to create a misleading impression in the mind of another person. A misrepresentation is material if a reasonable person would attach importance to it in making a decision or determining a course of action, including but not limited to, the issuance of a policy or coverage under a policy, calculation of rates, or payment of a claim.

Article 2: Benefits

Subscribers and their Enrolled Dependents are entitled to Benefits for Covered Health Services subject to the terms, conditions, limitations and exclusions set forth in the *Certificate(s) of Coverage* and *Schedule(s) of Benefits* attached to this Policy. Each *Certificate of Coverage* and *Schedule of Benefits*, including any Riders and Amendments, describes the Covered Health Services, required Copayments, and the terms, conditions, limitations and exclusions related to coverage.

Article 3: Premium Rates and Policy Charge

3.1 Premiums

Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Schedule of Premium Rates* in Exhibit 2 of this Policy or in any attached *Notice of Change*.

We reserve the right to change the *Schedule of Premium Rates* as described in Exhibit 1 of this Policy. We also reserve the right to change the *Schedule of Premium Rates* at any time if the *Schedule of Premium Rates* was based upon a Material Misrepresentation relating to health status that resulted in the Premium rates being lower than they would have been if the Material Misrepresentation had not been made. We reserve the right to change the *Schedule of Premium Rates* for this reason retroactive to the effective date of the *Schedule of Premium Rates* that was based on the Material Misrepresentation.

3.2 Computation of Policy Charge

The Policy Charge will be calculated based on the number of Subscribers in each Coverage Classification that we show in our records at the time of calculation. The Policy Charge will be calculated using the Premium rates in effect at that time. Exhibit 1 describes the way in which the Policy Charge is calculated.

3.3 Adjustments to the Policy Charge

We may make retroactive adjustments for any additions or terminations of Subscribers or changes in Coverage Classification that are not reflected in our records at the time we calculate the Policy Charge. We will not grant retroactive credit for any change occurring more than 60 days prior to the date we received notification of the change from the Enrolling Group. We also will not grant retroactive credit for any calendar month in which a Subscriber has received Benefits.

The Enrolling Group must notify us in writing within 60 days of the effective date of enrollments, terminations, or other changes. The Enrolling Group must notify us in writing each month of any change in the Coverage Classification for any Subscriber.

If premium taxes, guarantee or uninsured fund assessments, or other governmental charges relating to or calculated in regard to Premium are either imposed or increased, those charges will automatically be added to the Premium. In addition, any change in law or regulation that significantly affects our cost of operation will result in an increase in Premium in an amount we determine.

3.4 Payment of the Policy Charge

The Policy Charge is payable to us in advance by the Enrolling Group as described under "Payment of the Policy Charge" in Exhibit 1. The first Policy Charge is due and payable on or before the effective date of this Policy. Subsequent Policy Charges are due and payable no later than the first day of each payment period specified in item 6 of Exhibit 1, while this Policy is in force.

All payments shall be made in United States dollars, in immediately available funds, and shall be remitted to us at the address set forth in the Enrolling Group's application, or at such other address as we may from time to time designate in writing. The Enrolling Group agrees not to send us payments marked "paid in full", "without recourse", or similar language. In the event that the Enrolling Group sends such a payment, we may accept it without losing any of our rights under this Policy and the Enrolling Group will remain obligated to pay any and all amounts owed to us.

A late payment charge will be assessed for any Policy Charge not received within 10 calendar days following the due date. A service charge will be assessed for any non-sufficient-fund check received in payment of the Policy Charge. All Policy Charge payments must be accompanied by supporting documentation that states the names of the Covered Persons for whom payment is being made.

The Enrolling Group must reimburse us for attorney's fees and any other costs related to collecting delinquent Policy Charges.

3.5 Grace Period

A grace period of 31 days will be granted for the payment of any Policy Charge not paid when due. During the grace period, this Policy will continue in force. The grace period will not extend beyond the date this Policy terminates.

The Enrolling Group is liable for payment of the Policy Charge during the grace period. If we receive written notice from the Enrolling Group to terminate this Policy during the grace period, we will adjust the Policy Charge so that it applies only to the number of days this Policy was in force during the grace period.

This Policy terminates as described in Article 5.1 if the grace period expires and the past due Policy Charge remains unpaid.

Article 4: Eligibility and Enrollment

4.1 Eligibility Conditions or Rules

Eligibility conditions or rules for each class are stated in the corresponding Exhibit 2. The eligibility conditions stated in Exhibit 2 are in addition to those specified in *Section 3: When Coverage Begins* of the *Certificate of Coverage*.

4.2 Initial Enrollment Period

Eligible Persons and their Dependents may enroll for coverage under this Policy during the Initial Enrollment Period. The Initial Enrollment Period is determined by the Enrolling Group.

4.3 Open Enrollment Period

An Open Enrollment Period will be provided periodically for each class, as specified in the corresponding Exhibit 2. During an Open Enrollment Period, Eligible Persons may enroll for coverage under this Policy.

4.4 Effective Date of Coverage

The effective date of coverage for properly enrolled Eligible Persons and their Dependents is stated in Exhibit 2.

Article 5: Policy Termination

5.1 Conditions for Termination of the Entire Policy

This Policy and all Benefits for Covered Health Services under this Policy will automatically terminate on the earliest of the dates specified below:

- A. On the last day of the grace period if the Policy Charge remains unpaid. The Enrolling Group remains liable for payment of the Policy Charge for the period of time this Policy remained in force during the grace period.
- B. On the date specified by the Enrolling Group, after at least 31 days prior written notice to us that this Policy is to be terminated.
- C. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated due to the Enrolling Group's violation of the participation and contribution rules as shown in Exhibit 1.
- D. On the date we specify, after at least 31 days prior written notice to the Enrolling Group, that this Policy is to be terminated because the Enrolling Group performed an act, practice or omission that constituted fraud or made an intentional misrepresentation of a fact that was material to the execution of this Policy or to the provision of coverage under this Policy. In this case, we have the right to rescind this Policy back to either:
 - The effective date of this Policy.
 - The date of the act, practice or omission, if later.
- E. On the date we specify, after at least 90 days prior written notice to the Enrolling Group, that this Policy is to be terminated because we will no longer issue this particular type of group health benefit plan within the applicable market.
- F. On the date we specify, after at least 180 days prior written notice to the applicable state authority and to the Enrolling Group, that this Policy is to be terminated because we will no longer issue any employer health benefit plan within the applicable market.

5.2 Payment and Reimbursement Upon Termination

Upon any termination of this Policy, the Enrolling Group is and will remain liable to us for the payment of any and all Premiums which are unpaid at the time of termination, including a pro rata portion of the Policy Charge for any period this Policy was in force during the grace period preceding the termination.

Article 6: General Provisions

6.1 Entire Policy

This Policy, including the *Certificate(s) of Coverage*, the *Schedule(s) of Benefits*, the application of the Enrolling Group, and any Amendments, Notices of Change, and Riders, constitute the entire Policy between the parties. All statements made by the Enrolling Group or by a Subscriber will, in the absence of fraud, be deemed representations and not warranties and no such statements shall void the insurance or reduce Benefits unless contained in a written application for such insurance.

6.2 Limitation of Action

In the interest of saving time and money, the Enrolling Group is encouraged to complete the complaint procedures as described in *Section 6: Questions, Complaints and Appeals of the Certificate of Coverage* or pursue alternative dispute resolution such as mediation or arbitration prior to bringing any legal proceedings or action against us. If the Enrolling Group does not bring such legal proceeding or action against us within three years of the incident which gave rise to the complaint, the Enrolling Group forfeits its right to bring any action against us.

6.3 Time Limit on Certain Defenses

No statement made by the Enrolling Group, except a fraudulent statement, can be used to void this Policy after it has been in force for a period of two years.

6.4 Amendments and Alterations

Amendments to this Policy are effective 31 days after we send written notice to the Enrolling Group. Riders are effective on the date we specify. Other than changes to Exhibit 2 stated in a Notice of Change to Exhibit 2, no change will be made to this Policy unless made by an Amendment or a Rider which is signed by one of our authorized executive officers. No agent has authority to change this Policy or to waive any of its provisions.

6.5 Relationship between Parties

The relationships between us and Network providers, and relationships between us and Enrolling Groups, are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees, nor are we or any of our employees an agent or employee of Network providers or Enrolling Groups.

The relationship between a Network provider and any Covered Person is that of provider and patient. The Network provider is solely responsible for the services provided by it to any Covered Person. The relationship between any Enrolling Group and any Covered Person is that of employer and employee, Dependent, or any other category of Covered Person described in the Coverage Classifications specified in this Policy.

The Enrolling Group is solely responsible for enrollment and Coverage Classification changes (including termination of a Covered Person's coverage) and for the timely payment of the Policy Charges.

6.6 Records

The Enrolling Group must furnish us with all information and proofs which we may reasonably require with regard to any matters pertaining to this Policy. We may at any reasonable time inspect:

- All documents furnished to the Enrolling Group by an individual in connection with coverage.
- The Enrolling Group's payroll.
- Any other records pertinent to the coverage under this Policy.

By accepting Benefits under this Policy, each Covered Person authorizes and directs any person or institution that has provided services to him or her, to furnish us or our designees any and all information and records or copies of records relating to the health care services provided to the Covered Person. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form.

We agree that such information and records will be considered confidential. We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy including records necessary for appropriate medical review and quality assessment or as we are required by law or regulation.

During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy for research and analytic purposes.

6.7 Administrative Services

The services necessary to administer this Policy and the Benefits provided under it will be provided in accordance with our standard administrative procedures or those standard administrative procedures of our designee. If the Enrolling Group requests that administrative services be provided in a manner other than in accordance with these standard procedures, including requests for non-standard reports, the Enrolling Group must pay for such services or reports at the then current charges for such services or reports.

We may offer to provide administrative services to the Enrolling Group for certain wellness programs including, but not limited to, fitness programs, biometric screening programs and wellness coaching programs.

6.8 Employee Retirement Income Security Act (ERISA)

When this Policy is purchased by the Enrolling Group to provide benefits under a welfare plan governed by the federal *Employee Retirement Income Security Act* 29 U.S.C., 1001 et seq., we will not be named as, and will not be, the plan administrator or the named fiduciary of the welfare plan, as those terms are used in ERISA.

6.9 Examination of Covered Persons

In the event of a question or dispute concerning Benefits for Covered Health Services, we may reasonably require that a Network Physician, acceptable to us, examine the Covered Person at our expense.

6.10 Clerical Error

Clerical error will not deprive any individual of Benefits under this Policy or create a right to Benefits. Failure to report enrollments will not be considered a clerical error and will not result in retroactive coverage for Eligible Persons. Failure to report the termination of coverage will not continue the coverage for a Covered Person beyond the date it is scheduled to terminate according to the terms of this Policy. Upon discovery of a clerical error, any necessary appropriate adjustment in Premiums will be made. However, we will not grant any such adjustment in Premiums or coverage to the Enrolling Group for more than 60 days of coverage prior to the date we received notification of the clerical error.

6.11 Workers' Compensation Not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

6.12 Conformity with Law

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is deemed to be amended to conform to the minimum requirements of those statutes and regulations.

6.13 Notice

When we provide written notice regarding administration of this Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to Covered Persons on a timely basis.

We are not required to mail a notice of cancellation of the Policy to a Covered Person if:

- The Policy requires the Enrolling Group to mail promptly any such notice to the Covered Person;
- We mail or hand deliver a notice of cancellation to the Enrolling Group designated in the Policy, and we give a written reminder to the Enrolling Group of its obligation under the Policy; and
- We demonstrate that the Enrolling Group promptly provided proof of the mailing of a legible copy of the notice of cancellation to each Covered Person at the Covered Person's current address and the date the mailing occurred.

Any notice sent to us under this Policy and any notice sent to the Enrolling Group must be addressed as described in Exhibit 1.

6.14 Continuation Coverage

We agree to provide Benefits under this Policy for those Covered Persons who are eligible to continue coverage under federal or state law, as described in *Section 4: When Coverage Ends* of the *Certificate of Coverage*.

We will not provide any administrative duties with respect to the Enrolling Group's compliance with federal or state law. All duties of the plan sponsor or plan administrator remain the sole responsibility of the Enrolling Group, including but not limited to notification of COBRA and/or state law continuation rights and billing and collection of Premium.

6.15 Certification of Coverage Forms

As required by the federal *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*, we will produce certification of coverage forms for Covered Persons who lose coverage under this Policy. The Enrolling Group agrees to provide us with all necessary eligibility and termination data. Certification of coverage forms will be based on eligibility and termination data that the Enrolling Group provides to our eligibility systems in accordance with our data specifications, and which is available in our eligibility systems as of the date the form is generated. The certification of coverage forms will only include periods of coverage that we administer under this Policy.

6.16 Subscriber's Individual Certificate

We will issue *Certificate(s) of Coverage, Schedule(s) of Benefits*, and any attachments to the Enrolling Group for delivery to each covered Subscriber. The *Certificate(s) of Coverage, Schedule(s) of Benefits*, and any attachments will show the Benefits and other provisions of this Policy. In addition, you may have access to your *Certificate(s) of Coverage* and *Schedule(s) of Benefits* online at www.myuhc.com.

6.17 Summary of Benefits and Coverage

We will provide a *Summary of Benefits and Coverage* ("SBC"), as required by the *Affordable Care Act* and associated regulations ("ACA"), to the Enrolling Group for each benefit plan purchased by the Enrolling Group. The Enrolling Group shall be responsible for delivering the SBC to all Covered Persons and to other persons eligible for coverage in the manner and at the times required by the ACA, unless we notify the Enrolling Group that we will deliver the SBC to Covered Persons and other persons eligible for coverage.

6.18 System Access

The term "systems" as used in this provision means our systems that we make available to the Enrolling Group to facilitate the transfer of information in connection with this Policy.

System Access

We grant the Enrolling Group the nonexclusive, nontransferable right to access and use the functionalities contained within the systems, under the terms set forth in this Policy. The Enrolling Group agrees that all rights, title and interest in the systems and all rights in patents, copyrights, trademarks and trade secrets encompassed in the systems will remain ours. In order to obtain access to the systems, the Enrolling Group will obtain, and be responsible for maintaining, at no expense to us, the hardware, software and Internet browser requirements we provide to the Enrolling Group, including any amendments to those requirements. The Enrolling Group is responsible for obtaining an internet service provider or other access to the Internet.

The Enrolling Group will not:

- Access systems or use, copy, reproduce, modify, or excerpt any of the systems documentation provided by us in order to access or utilize systems, for purposes other than as expressly permitted under this Policy.
- Share, transfer or lease its right to access and use systems, to any other person or entity which is not a party to this Policy.

The Enrolling Group may designate any third party to access systems on its behalf, provided the third party agrees to these terms and conditions of systems access and the Enrolling Group assumes joint responsibility for such access.

Security Procedures

The Enrolling Group will use commercially reasonable physical and software-based measures, and comply with our security procedures, as may be amended from time to time, to protect the system, its functionalities, and data accessed through systems from any unauthorized access or damage (including damage caused by computer viruses). The Enrolling Group will notify us immediately if any breach of the security procedures, such as unauthorized use, is suspected.

System Access Termination

We reserve the right to terminate the Enrolling Group's system access:

- On the date the Enrolling Group fails to accept the hardware, software and browser requirements provided by us, including any amendments to the requirements.
- Immediately on the date we reasonably determine that the Enrolling Group has breached, or allowed a breach of, any applicable provision of this Policy. Upon termination of this Policy, the Enrolling Group agrees to cease all use of systems, and we will deactivate the Enrolling Group's identification numbers and passwords and access to the system.

Exhibit 1

1. **Parties.** The parties to this Policy are UnitedHealthcare Insurance Company and GANDY CORPORATION, the Enrolling Group.
2. **Effective Date of this Policy.** The effective date of this Policy is 12:01 a.m. on April 1, 2015 in the time zone of the Enrolling Group's location.
3. **Place of Issuance.** We are delivering this Policy in the State of New Mexico. This Policy is governed by ERISA. To the extent that state law applies, the laws of the State of New Mexico are the laws that govern this Policy.
4. **Premiums.** We reserve the right to change the *Schedule of Premium Rates* or Cost Summary specified in each Exhibit 2, after a 60-day prior written notice on the first anniversary of the effective date of this Policy specified in the application or on any monthly due date thereafter, or on any date the provisions of this Policy are amended. We also reserve the right to change the Schedule of Premium Rates, retroactive to the effective date, if a Material Misrepresentation relating to health status has resulted in a lower schedule of rates.
5. **Computation of Policy Charge.**
A full month's Premium will be charged for any Covered Person who is covered under this Policy for any portion of a calendar month.
6. **Payment of the Policy Charge.** The Policy Charge is payable to us in advance by the Enrolling Group on a monthly basis.
7. **Minimum Participation Requirement.** The minimum participation requirement for the Enrolling Group is 75% of Eligible Persons excluding spousal waivers but no less than 50% of all Eligible Persons must be enrolled for coverage under this Policy.
8. **Minimum Contribution Requirement.** The Enrolling Group must maintain a minimum contribution requirement of 50% of the Premium for each Eligible Person.
9. **Notice.** Any notice sent to us under this Policy must be addressed to:
UnitedHealthcare Insurance Company
185 Asylum Street
Hartford, CT 06103-3408

Any notice sent to the Enrolling Group under this Policy must be addressed to:
GANDY CORPORATION
1623 S MAIN
LOVINGTON, NM 882600000
10. G/GA5U2205NM Enrolling Group Number

Exhibit 2

1. **Class Description.**

See Application.

2. **Eligibility.** The eligibility rules are established by the Enrolling Group. The following eligibility rules are in addition to the eligibility rules specified in the Employer Application and/or in *Section 3: When Coverage Begins* of the *Certificate of Coverage*:

A. The waiting or probationary period for newly Eligible Persons is as follows:

60 days

As required by federal law, for policies that are new or renewing on or after January 1, 2014, the waiting period limitation cannot be greater than 90 days as described in item 4 below.

B. Other:

None

3. **Open Enrollment Period.** An Open Enrollment Period of at least 31 days will be provided by the Enrolling Group during which Eligible Persons may enroll for coverage. The Open Enrollment Period will be provided on an annual basis.

4. **Effective Date for Eligible Persons.** The effective date of coverage for Eligible Persons who are eligible on the effective date of this Policy is April 1, 2015 .

For an Eligible Person who becomes eligible after the effective date of this Policy, his or her effective date of coverage is the first day of the month following the last day of the required waiting period. Any required waiting period will not exceed 90 days.

5. **Schedule of Premium Rates.**

Monthly Premiums payable by or on behalf of Covered Persons are specified in the *Cost Summary* detailed through the new business premium confirmation process and renewal package.

Exhibit 3

NOTICE OF PROTECTION PROVIDED BY NEW MEXICO LIFE INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the New Mexico Life Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under New Mexico law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with New Mexico law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
 - \$300,000 in death benefits
 - \$100,000 in cash surrender or withdrawal values
- Health Insurance
 - \$500,000 in hospital, medical and surgical insurance benefits
 - \$300,000 in disability income insurance benefits
 - \$300,000 in long-term care insurance benefits
 - \$100,000 in other types of health insurance benefits
- Annuities
 - \$250,000 in present value of annuity benefits

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000 (\$500,000 for hospital, medical and surgical insurance policies).

Note to benefit plan trustees or other holders of unallocated annuities covered under the act: For unallocated annuities that fund certain governmental retirement plans, the limit is \$250,000 in present value of annuity benefits per plan participant. For covered unallocated annuities that fund other plans, a special limit of \$5,000,000 applies to each contract holder, regardless of the number of contracts held or number of persons covered.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under New Mexico law. To learn more about the above protections, please visit the Association's website at www.nmlifega.org, or contact:

New Mexico Life Insurance
Guaranty Association
PO Box 2880
Santa Fe, NM 87504-2880
505-820-7355

New Mexico Office of the
Superintendent of Insurance
PO Box 1689
Santa Fe, NM 87504-1689
855-427-5674

Insurance companies and agents are not allowed by New Mexico law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and New Mexico law, then New Mexico law will control.



STATEMENT OF PLAN YEAR

Important Notice:

Federal health care law will often apply to your group health plan as of the first day of the Plan Year beginning after the effective date of the new law.

In the vast majority of situations, a group's Plan Year and its insurance Policy Year are the same twelve month period of time. "Plan Year" means the twelve month period that is listed in your plan document. "Policy Year" means the twelve month period from the policy's issuance date (or last renewal date) and its next renewal date.

Consequently, we are administering this insurance policy consistent with the presumption that your Plan Year and insurance Policy Year are the same twelve month period of time.

If this information is not correct please contact your UnitedHealthcare representative as soon as possible.

UnitedHealthcare Insurance Company

UnitedHealthcare Choice Plus

Certificate of Coverage, Riders, Amendments, and Notices

for

GANDY CORPORATION

Group Number: G/GA5U2205NM **Health Plan:** YE - V **Prescription Code:** 5Y
Effective Date: April 1, 2015

Offered and Underwritten by
UnitedHealthcare Insurance Company

Riders, Amendments, and Notices
begin immediately following the last page
of the Certificate of Coverage

Certificate of Coverage

UnitedHealthcare Insurance Company

185 Asylum Street

Hartford, Connecticut 06103-3408

1-800-357-1371

Certificate of Coverage is Part of Policy

This *Certificate of Coverage (Certificate)* is part of the Policy that is a legal document between UnitedHealthcare Insurance Company and the Enrolling Group to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of the Policy. We issue the Policy based on the Enrolling Group's application and payment of the required Policy Charges.

In addition to this *Certificate* the Policy includes:

- The *Group Policy*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders, including the Outpatient Prescription Drug Rider.
- Amendments.

You can review the Policy at the office of the Enrolling Group during regular business hours.

Changes to the Document

We may from time to time modify this *Certificate* by attaching legal documents called Riders and/or Amendments that may change certain provisions of this *Certificate*. When that happens we will send you a new *Certificate*, Rider or Amendment pages.

No one can make any changes to the Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate the Policy, as permitted by law, without your approval.

On its effective date, this *Certificate* replaces and overrules any *Certificate* that we may have previously issued to you. This *Certificate* will in turn be overruled by any *Certificate* we issue to you in the future.

The Policy will take effect on the date specified in the Policy. Coverage under the Policy will begin at 12:01 a.m. and end at 12:00 midnight in the time zone of the Enrolling Group's location. The Policy will remain in effect as long as the Policy Charges are paid when they are due, subject to termination of the Policy.

We are delivering the Policy in the State of New Mexico. The Policy is governed by ERISA unless the Enrolling Group is not an employee welfare benefit plan as defined by ERISA. To the extent that state law applies, the laws of the State of New Mexico are the laws that govern the Policy.

NOTICE REQUIRED BY THE STATE OF NEW MEXICO SUPERINTENDENT OF TO COVERED PERSONS REGARDING THE MOTHERS AND NEWLY-BORN CHILDREN HEALTH SECURITY RULE EFFECTIVE MARCH 1, 1996

In 1995 the State of New Mexico passed the *Mothers and Newly Born Children Health Security Rule*. This Rule sets the minimum length of hospital stay after delivery that all health care insurers must provide for mothers who want it. If a mother, in agreement with her Physician, chooses to go home earlier than the minimum, the rule requires that benefits for postpartum care must be provided in the home.

Upon consultation with the attending Physician, the Covered Person can choose;

- The minimum length of hospital stay as explained below, or
- Postpartum care in the home as explained below.

The mother may be discharged from the Hospital earlier if the mother and the Physician agree and if the mother's medical condition meets the requirements of the most current version of the *Guidelines for Perinatal Care* prepared by the *American Academy of Pediatrics* and the *American College of Obstetricians and Gynecologists*. One of those requirements is that family members or other support persons will be available to help the new mother for the first few days following early discharge. Postpartum care consists of a minimum of three home visits, unless one or two home visits are determined to be sufficient by the mother and the attending Physician. Following delivery of the baby, the plan will provide coverage for home visits by a person with appropriate licensure, training, and experience to provide postpartum care. Services provided will include, but not be limited to, parent education, assistance and training in breast and bottle feeding, and the performance of any necessary and appropriate clinical tests. The home visits will be conducted within the time period ordered by the attending Physician or the person providing postpartum care.

The Covered Person has the right to complain to the New Mexico Office of *Superintendent of Insurance* if there is concern that the mother or child did not receive the coverage required by this rule. *The Superintendent of Insurance* can be reached by phone at 1-855-4ASK-OSI or 1-855-427-5674 or (505)827-4601 when dialing from Santa Fe. The mailing address is:

Office of the Superintendent of Insurance

Post Office Box 1689

Santa Fe, New Mexico 87504-1689

Please feel free to contact us at the telephone number for *Customer Care* listed on your ID card with any questions regarding this notice or any other health insurance related issues.

Introduction to Your Certificate

We are pleased to provide you with this *Certificate*. This *Certificate* and the other Policy documents describe your Benefits, as well as your rights and responsibilities, under the Policy.

How to Use this Document

We encourage you to read your *Certificate* and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this *Certificate* by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 8: General Legal Provisions* to better understand how this *Certificate* and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this *Certificate* are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your *Certificate* and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this *Certificate* and any summaries provided to you by the Enrolling Group, this *Certificate* will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this *Certificate* is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 9: Defined Terms*. You can refer to *Section 9: Defined Terms* as you read this document to have a clearer understanding of your *Certificate*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 9: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your ID card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Contributions

Benefits are available to you only if you are enrolled for coverage under the Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins*. To be enrolled with us and receive Benefits, both of the following apply:

- Your enrollment must be in accordance with the Policy issued to your Enrolling Group, including the eligibility requirements.
- You must qualify as a Subscriber or his or her Dependent as those terms are defined in *Section 9: Defined Terms*.

Your Enrolling Group may require you to make certain payments to them, in order for you to remain enrolled under the Policy and receive Benefits. If you have questions about this, contact your Enrolling Group.

Be Aware this Benefit Plan Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services. The extent of this Benefit plan's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver. Network providers are not required to comply with any specified numbers, targeted averages, or maximum duration of patient visit requirements.

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Benefit plan's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Benefit plan for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We make administrative decisions regarding whether this Benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received. Our decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We have the ability to do the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this discretionary authority to other persons or entities that may provide administrative services for this Benefit plan, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Benefit plan.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of our reimbursement policies for yourself or to

share with your non-Network Physician or provider by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary except for preventive care services as described for which Benefits are available as described in this section. (See definitions of Medically Necessary and Covered Health Service in *Section 9: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Policy.
- Covered Health Services are received while the Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements specified in the Policy.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Acupuncture Services

Acupuncture services for the following conditions:

- Pain therapy.
- Nausea that is related to surgery, Pregnancy or chemotherapy.

Acupuncture services must be performed in an office setting by a provider who is one of the following, either practicing within the scope of his/her license (if state license is available) or who is certified by a national accrediting body:

- Doctor of Medicine.
- Doctor of Osteopathy.
- Chiropractor.
- Acupuncturist.

2. Ambulance Services

Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance) to the nearest Hospital where Emergency Health Services can be performed.

Benefits include transportation, including air transport, when necessary to protect the life of the infant or mother, for medically high-risk pregnant women with an impending delivery of a potentially viable infant to the nearest available Tertiary Care Facility for newly-born infants.

Non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as we determine appropriate) between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.
- From an acute facility to a sub-acute setting.

3. Clinical Trials

Cancer Clinical Trials

Covered Health Services for routine patient care costs incurred as a result of a Covered Person's participation in an approved phase II, III or IV cancer clinical trial if the trial meets all of the following:

- The cancer clinical trial is for the purpose of the prevention of or the prevention of reoccurrence of cancer, or the early detection or treatment of cancer for which no equally or more effective standard cancer treatment exists;
- The cancer clinical trial is not designed exclusively to test toxicity or disease pathophysiology and it has a therapeutic intent;
- The cancer clinical trial is being provided in this state as part of a scientific study of a new therapy or intervention and is for the prevention of reoccurrence, early detection, treatment or palliation of cancer in humans. A scientific study includes all of the following:
 - Specific goals;
 - A rationale and background for the study;
 - Criteria for patient selection;
 - Specific direction for administering the therapy or intervention and for monitoring patients;
 - A definition of quantitative measures for determining treatment response;
 - Methods for documenting and treating adverse reactions; and
 - A reasonable expectation that the treatment will be at least as efficacious as standard cancer treatment.
- The cancer clinical trial is being conducted with approval of at least one of the following:
 - One of the federal *National Institutes of Health (NIH)*;
 - A federal *National Institutes of Health Cooperative Group or Center*;
 - *Department of Defense (DOD)*;
 - The *U.S. Food and Drug Administration (FDA)* in the form of an investigational new drug application;
 - *Veterans Administration (VA)*;
 - A qualified research entity that meets the criteria established by the federal *National Institutes of Health (NIH)* for grant eligibility;
- There is no non-investigational treatment equivalent to the cancer clinical trial; and
- The available clinical or preclinical data provide a reasonable expectation that the cancer clinical trial will be at least as effective as any non-investigational alternative.
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment.

For the purpose this section, "routine patient care cost for cancer clinical trials" means:

- A medical service or treatment that would be covered if the patient were receiving standard cancer treatment; or
- A drug provided during a cancer clinical trial if the drug has been approved by the *U.S. Food and Drug Administration (FDA)* whether or not that organization has approved the drug for use in treating the particular condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or provider of the drug.

Routine patient care cost does not include:

- The cost of an Experimental or Investigational drug or device or procedure;
- The cost of a non-health care service received as a result of participation in the cancer clinical trial;
- Costs associated with managing the research of the cancer clinical trial;
- Costs that would not be covered if non-investigational treatment were provided;
- Cost of those tests that are necessary for the research of the cancer clinical trial; and
- Cost paid or not charged for by the cancer clinical trial providers.

Pursuant to the patient informed consent document, no third party is liable for damages associated with the treatment provided during a phase of a cancer clinical trial.

Other Qualifying Clinical Trials

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
 - Certain *Category B* devices. *Category B devices* (Non-Experimental, but still Investigational) means a device type in which the underlying questions of safety and effectiveness of that device type have been resolved, or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained *U.S. Food and Drug Administration (FDA)* approval for the device type. These devices are under investigation to establish substantial equivalence to a predicate device, that is, to establish substantial equivalence to a previously/currently legally marketed device.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
 - *The Department of Veterans Affairs, the Department of Defense or the Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ◆ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ◆ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

4. Congenital Heart Disease Surgeries

Congenital heart disease (CHD) surgeries which are ordered by a Physician. CHD surgical procedures include surgeries to treat conditions such as coarctation of the aorta, aortic stenosis, tetralogy of fallot, transposition of the great vessels and hypoplastic left or right heart syndrome.

Benefits under this section include the facility charge and the charge for supplies and equipment. Benefits for Physician services are described under *Physician Fees for Surgical and Medical Services*.

Surgery may be performed as open or closed surgical procedures or may be performed through interventional cardiac catheterization.

We have specific guidelines regarding Benefits for CHD services. Contact us at the telephone number on your ID card for information about these guidelines.

5. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

- The dental damage is severe enough that initial contact with a Physician or dentist occurred within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within three months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).
- Treatment must be completed within 12 months of the accident.

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

6. Diabetes Services

For purposes of this section, diabetes includes the following:

- Insulin-using diabetes.
- Non-insulin using diabetes.
- Elevated blood glucose levels during pregnancy.

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.

For Covered Persons with diabetes, Benefits under the section also include:

- Medical eye examinations (dilated retinal examinations).
- Preventive foot care, including:
 - Therapeutic molded or depth-inlay shoes.
 - Functional orthotics.
 - Custom molded inserts and replacement inserts.
 - Preventive devices.
 - Shoe modification.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*. Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices, injection aids, including those adaptable for the legally blind, glucagon emergency kits, prescriptive oral agents for controlling blood sugar and insulin are

described under the *Outpatient Prescription Drug Rider*.

7. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use primarily in a home setting.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.
- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this *Certificate*.

Benefits under this section also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated in the *Schedule of Benefits*.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost or stolen items.

8. Emergency Health Services - Outpatient

Services that are required to stabilize or initiate treatment in an Emergency. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

9. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing, for Enrolled Dependent children under the age of 18, or under the age of 21 if the child is still attending high school, this includes ear molds as necessary to maintain optimal fit as provided by an audiologist, a hearing aid dispenser or a Physician.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this *Certificate*, only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

10. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.
- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

11. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, spiritual and respite care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

12. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Benefits also include Inpatient Stays as follows:

- 48 hours following a mastectomy.
- 24 hours following a lymph node dissection for the treatment of breast cancer.

An Inpatient Stay can be for a shorter period of time if the Physician and Covered Person agree it is appropriate.

13. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury*.

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

14. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

15. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

16. Neurobiological Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorders that are both of the following:

- Provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories in this *Certificate*.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA)).

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

17. Obesity Surgery

Surgical treatment of obesity when provided by or under the direction of a Physician when the Covered Person has a body mass index (BMI) greater than 40.

Surgical treatment of obesity when provided by or under the direction of a Physician when either of the following criteria is met:

- The Covered Person must have a body mass index (BMI) of greater than 40.
- The Covered Person must have a body mass index (BMI) of greater than 35 with complicating comorbidities (such as sleep apnea or diabetes) directly related to, or exacerbated by, obesity.

18. Ostomy Supplies

Benefits for ostomy supplies are limited to the following:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.

Benefits are not available for deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover, or other items not listed above.

19. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

20. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

21. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

22. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

If the mother and newborn child are discharged earlier than the minimum time frames listed above, Benefits for postpartum care will be provided for a minimum of three home visits, unless the mother and the attending provider agree that one or two home visits are sufficient.

The home visits for postpartum care must be provided by a person with appropriate licensure, training, and experience to provide postpartum care.

Benefits are included for, but not limited to, the following services:

- Parent education.
- Assistance and training in breast and bottle feeding.
- The performance of any necessary and appropriate clinical tests.

In addition to the above services, Benefits include:

- Alpha-fetoprotein IV screening tests to screen for genetic abnormalities in the fetus that are generally given between week 16 and 20 of pregnancy.
- Circumcision of a newborn male baby.

23. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.

- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*, including child immunizations and medically necessary booster doses in accordance with the current schedule of immunizations recommended by the *American Academy of Pediatrics*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

As required under New Mexico insurance law, Benefits under this section specifically include:

- Screening mammography:
 - For a woman who is at least 35 years of age, but under 40 years of age, one baseline screening mammography.
 - For a woman who is at least 40 years of age, but under 50 years of age, one mammogram every two years.
 - For a woman who is at least 50 years of age, an annual mammogram.
- Screening colonoscopy or sigmoidoscopy.
- Cytology screening for determining the presence of precancerous or cancerous conditions and other health problems as determined by a Physician in accordance with national medical standards for covered women who are 18 years of age or older and for women who are at risk for cancer or other health conditions that can be identified through cytologic screening. Cytology screening means a papanicolaou test and a pelvic exam for symptomatic as well as asymptomatic women.
- Human papillomavirus screening once every three years for women age 30 and over.
- Human papillomavirus vaccine for Enrolled Dependent females age 9 to 14.
- An annual consultation with a health professional to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, immunization practices, breast self-examination, testicular self-examination, use of seatbelts in motor vehicles, and other preventative health care practices for Covered Persons 20 years of age or older and as recommended by a Physician.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. You can obtain additional information on how to access Benefits for breast pumps by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

24. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, except that:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

25. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Cosmetic Procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

26. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

Short-term outpatient rehabilitation services, (including habilitative services), limited to:

- Physical therapy.
- Occupational therapy.
- Manipulative Treatment.
- Speech therapy.
- Pulmonary rehabilitation therapy.
- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under *Habilitative Services* above, please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

27. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

28. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

29. Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.

Benefits include the following services provided on an inpatient basis:

- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance Use Disorder Designee for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Designee may become available to you as a part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under the Policy. You must be referred to such programs through the Mental Health/Substance Use Disorder Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

30. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

31. Temporomandibular Joint and Craniomandibular Disorder Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and craniomandibular disorder services and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

32. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

33. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service.

Examples of transplants for which Benefits are available include bone marrow, heart, heart/lung, lung, kidney, kidney/pancreas, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

34. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

Additional Benefits Required By New Mexico Law

35. Dental Services - Hospitalization and General Anesthesia

Benefits include hospitalization and general anesthesia for dental surgery provided in a Hospital or an Alternate Facility for:

- A Covered Person who exhibits physical, intellectual or medically compromising conditions for which dental treatment under local anesthesia, with or without additional adjunctive techniques and modalities, cannot be expected to provide a successful result and for which dental treatment under general anesthesia can be expected to produce superior results.
- A Covered Person for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy.
- An Enrolled Dependent child or adolescent who is extremely uncooperative, fearful, anxious or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity.
- A Covered Person with extensive oral-facial or dental trauma for which treatment under local anesthesia would be ineffective or compromised.
- Other procedures for which hospitalization or general anesthesia in a Hospital or Alternate Facility is medically necessary.

36. Early Intervention Services

Benefits are provided for early intervention services provided to children, from birth through three years of age, who have been identified as having or at risk of having developmental delay or disabilities, for or under the *Family Infant Toddler Program* administered by the *New Mexico Department of Health*.

Services must be provided as part of an individualized family service plan designed to meet the developmental needs of the child and the needs of the family related to enhancing the child's development, and must be delivered by certified and licensed personnel who are working in early intervention programs approved by the *New Mexico Department of Health*.

Services include:

- Assistive technology.
- Audiological and vision.
- Speech and language pathology.
- Developmental consultation.
- Family training, including counseling and home visits.
- Social work.
- Nutritional.
- Health, medical and nursing services.
- Occupational and physical therapy services.
- Psychological services.
- Respite.
- Transportation.

37. Genetic Inborn Errors of Metabolism

Benefits are provided for the treatment of Genetic Inborn Errors of Metabolism that involve amino acid, carbohydrate and fat metabolism for which medically standard methods of diagnosis, treatment and monitoring exists. Benefits include diagnosing, monitoring and controlling disorders by nutritional and medical assessment, including clinical services, biochemical analysis, prescription drugs, medical supplies, corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management and Special Medical Foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

Prescription drugs and Special Medical Foods described above that are prescribed by a Physician for the treatment and management of Genetic Inborn Errors of Metabolism are provided under the *Outpatient Prescription Drug Rider*.

38. Osteoporosis Treatment

Benefits are provided for diagnosis, treatment and appropriate management of osteoporosis. Covered Health Services include all *U.S. Food and Drug Administration (FDA)* approved technologies including bone mass measurement as recommended by a Physician.

39. Smoking Cessation Treatment

Benefits are provided for the following:

- Diagnostic services necessary to identify tobaccos use or use-related conditions and dependence.
- Pharmacotherapy, as described under the *Outpatient Prescription Drug Rider*.
- Cessation counseling.

Initiation of any course of pharmacotherapy or cessation counseling shall constitute an entire course regardless if the Covered Person discontinues or fails to complete the course.

For purposes of this Benefit, "Cessation counseling" means a program, including individual, group, or proactive telephone quit line, that:

- Is designed to build positive behavior change practices and provides counseling at a minimum on establishment of reasons for quitting tobacco use, understanding nicotine addiction, various techniques for quitting tobacco use and remaining tobacco free, discussion of stages of change, overcoming the problems of quitting, including withdrawal symptoms, short-term goal setting, setting a quit date, relapse prevention information and follow-up.
- Operates under a written program outline, that at a minimum includes an overview of service, service objectives and key topics covered, general teaching/learning strategies, clearly stated methods of assessing participant success, description of audio or visual materials that will be used, distribution plan for patient education material and method for verifying enrollee attendance.

- Employs counselors who have formal training and experience in tobacco cessation programming and are active in relevant continuing education activities.
- Uses a formal evaluation process, including mechanisms for data collections and measuring participant rate and impact of the program.

40. Telemedicine Services

Coverage is provided for Telemedicine services the same as other Covered Health Services.

For the purposes of this Benefit, Telemedicine is the use of interactive simultaneous audio and video or other technology using information and telecommunications technologies by a health care provider to deliver health care services at a site other than the site where the patient is located. Unless the consulting Telemedicine provider deems it necessary, there is no requirement that a health care provider be physically present with a patient at the originating site. The coverage of this Health Service does not require coverage of an otherwise non-covered benefit.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to the Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia), except as described under *Dental Services - Hospitalization and General Anesthesia* in *Section 1: Covered Health Services*.

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.

3. Dental implants, bone grafts and other implant-related procedures. This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.
4. Dental braces (orthodontics).
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly. This exclusion does not apply to the following:
 - Newborn children if due a Congenital Anomaly.
 - Correction of non-dental physiological conditions which has resulted in severe functional impairment.
 - Treatment of tumors and cysts requiring pathological examinations of the jaws, cheeks, lips, tongue, roof and floor of month.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces, except as described under *Diabetes Services* in *Section 1: Covered Health Services*.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.
 - Trusses.
 - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
6. Oral appliances for snoring.

7. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
8. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Prescription drug products for outpatient use that are filled by a prescription order or refill.
2. Self-injectable medications. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
3. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
4. Over-the-counter drugs and treatments.
5. Growth hormone therapy.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes, except as described under *Diabetes Services* in *Section 1: Covered Health Services*.
7. Shoe orthotics, except as described under *Diabetes Services* in *Section 1: Covered Health Services*.
8. Shoe inserts, except as described under *Diabetes Services* in *Section 1: Covered Health Services*.
9. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - Compression stockings.
 - Ace bandages.

- Gauze and dressings.
- Urinary catheters.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
 - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
 - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
 3. Medical equipment of any kind. This exclusion does not apply to insulin pumps for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.

H. Mental Health

Exclusions listed directly below apply to services described under *Mental Health Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services as treatments for V-code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.
5. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
7. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
8. Mental retardation and autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.
9. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

I. Neurobiological Disorders - Autism Spectrum Disorders

Exclusions listed directly below apply to services described under *Neurobiological Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

1. Services as treatments of sexual dysfunction and feeding disorders as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
3. Mental retardation as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
4. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
5. Learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.
6. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias.
7. Services or supplies for the diagnosis or treatment of Mental Illness that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's Mental Illness or condition based on generally accepted standards of medical practice and benchmarks.

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

This exclusion does not apply to Benefits described under *Early Intervention Services* listed under *Additional Benefits Required By New Mexico Law* in *Section:1 Covered Health Services*.

2. Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to Benefits described under *Genetic Inborn Errors of Metabolism* listed under *Additional Benefits Required By New Mexico Law* in *Section:1 Covered Health Services*.
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods). This exclusion does not apply to Benefits described under *Genetic Inborn Errors of Metabolism* listed under *Additional Benefits Required By New*

Mexico Law in Section:1 Covered Health Services, or to medical nutritional supplements as part of an expectant mother's prenatal care, as determined by a Physician.

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries and battery chargers.
 - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.
 - Home modifications such as elevators, handrails and ramps.
 - Hot tubs.
 - Humidifiers.
 - Jacuzzis.
 - Mattresses.
 - Medical alert systems.
 - Motorized beds.
 - Music devices.
 - Personal computers.
 - Pillows.
 - Power-operated vehicles.
 - Radios.
 - Saunas.
 - Stair lifts and stair glides.
 - Strollers.
 - Safety equipment.
 - Treadmills.
 - Vehicle modifications such as van lifts.
 - Video players.
 - Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 9: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal or replacement by any means.

This exclusion does not apply to Cosmetic Procedures that improvement in physiology could reasonably be expected, when ordered by a Physician for correction of functional disorders resulting from an Injury or an Congenital Anomaly.

2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

M. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly or Autism Spectrum Disorders, or for Benefits described under *Early Intervention Services* listed under *Additional Benefits Required By New Mexico Law* in *Section 1: Covered Health Services*.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.
9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback.

11. The following services for the diagnosis and treatment of TMJ: surface electromyography; Doppler analysis; vibration analysis; computerized mandibular scan or jaw tracking; craniosacral therapy; orthodontics; occlusal adjustment; and dental restorations.
12. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. This exclusion does not apply to Benefits described under *Temporomandibular Joint and Craniomandibular Disorder Services* in *Section 1: Covered Health Services*.
13. Surgical and non-surgical treatment of obesity.
14. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings.
15. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.
16. In vitro fertilization regardless of the reason for treatment.

N. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
 - Has not been actively involved in your medical care prior to ordering the service, or
 - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

O. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.

P. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

Q. Substance Use Disorders

Exclusions listed directly below apply to services described under *Substance Use Disorder Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Services or supplies for the diagnosis or treatment of alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Designee, are any of the following:
 - Not consistent with generally accepted standards of medical practice for the treatment of such conditions.
 - Not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental.
 - Not consistent with the Mental Health/Substance Use Disorder Designee's level of care guidelines or best practices as modified from time to time.
 - Not clinically appropriate for the patient's substance use disorder or condition based on generally accepted standards of medical practice and benchmarks.

R. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under the Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

S. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.
2. Travel or transportation expenses, even though prescribed by a Physician. Some travel expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services*.

This exclusion does not apply to Benefits described under *Early Intervention Services* listed under *Additional Benefits Required By New Mexico Law* in *Section:1 Covered Health Services* or Benefits described under *Ambulance Services* in *Section:1 Covered Health Services*.

T. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.

3. Domiciliary care.
4. Private Duty Nursing.
5. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in *Section 1: Covered Health Services* or to Benefits described under *Early Intervention Services* listed under *Additional Benefits Required By New Mexico Law* in *Section:1 Covered Health Services*.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

U. Vision and Hearing

These exclusions do not apply to Benefits described under *Early Intervention Services* listed under *Additional Benefits Required By New Mexico Law* in *Section:1 Covered Health Services*.

1. Purchase cost and fitting charge for eyeglasses and contact lenses, except as required for corrective lenses as described under *Genetic Inborn Error of Metabolism* listed under *Additional Benefits Required By New Mexico Law* in *Section:1 Covered Health Services*.
2. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
3. Eye exercise or vision therapy.
4. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
5. Bone anchored hearing aids except when either of the following applies:
 - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
 - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 9: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - ◆ Medically Necessary.
 - ◆ Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - ◆ Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Policy when:
 - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.

- Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.
 - Required to obtain or maintain a license of any type.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
 4. Health services received after the date your coverage under the Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under the Policy ended.
 5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Policy.
 6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
 7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
 8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
 9. Autopsy.
 10. Foreign language and sign language services.
 11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins

How to Enroll

Eligible Persons must complete an enrollment form. The Enrolling Group will give the necessary forms to you. The Enrolling Group will then submit the completed forms to us, along with any required Premium. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. For Benefit plans that have a Network Benefit level, Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Enrolling Group determines who is eligible to enroll under the Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person usually refers to an employee or member of the Enrolling Group who meets the eligibility rules. When an Eligible Person actually enrolls, we refer to that person as a Subscriber. For a complete definition of Eligible Person, Enrolling Group and Subscriber, see *Section 9: Defined Terms*.

Eligible Persons must reside within the United States.

If both spouses are Eligible Persons of the Enrolling Group, each may enroll as a Subscriber or be covered as an Enrolled Dependent of the other, but not both.

Dependent

Dependent generally refers to the Subscriber's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 9: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under the Policy.

If both parents of a Dependent child are enrolled as a Subscriber, only one parent may enroll the child as a Dependent.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Initial Enrollment Period

When the Enrolling Group purchases coverage under the Policy from us, the Initial Enrollment Period is the first period of time when Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified in the Policy if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Open Enrollment Period

The Enrolling Group determines the Open Enrollment Period. During the Open Enrollment Period, Eligible Persons can enroll themselves and their Dependents.

Coverage begins on the date identified by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the Eligible Person becomes eligible to enroll.

Dependent Child Special Open Enrollment Period

On or before the first day of the first plan year beginning on or after September 23, 2010, the Enrolling Group will provide a 30 day dependent child special open enrollment period for Dependent children who are not currently enrolled under the Policy and who have not yet reached the limiting age. During this dependent child special open enrollment period, Subscribers who are adding a Dependent child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the plan year beginning on or after September 23, 2010, if we receive the completed enrollment form and any required Premium within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

New Eligible Persons

Coverage for a new Eligible Person and his or her Dependents begins on the date agreed to by the Enrolling Group if we receive the completed enrollment form and any required Premium within 31 days of the date the new Eligible Person first becomes eligible.

Adding New Dependents

Subscribers may enroll Dependents who join their family because of any of the following events:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.
- Legal guardianship.
- Court or administrative order.

Coverage for the Dependent begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event that makes the new Dependent eligible.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period. A special enrollment period is not available to an Eligible Person and his or her Dependents if coverage under the prior plan was terminated for cause, or because premiums were not paid on a timely basis.

An Eligible Person and/or Dependent does not need to elect COBRA continuation coverage to preserve special enrollment rights. Special enrollment is available to an Eligible Person and/or Dependent even if COBRA is not elected.

A special enrollment period applies to an Eligible Person and any Dependents when one of the following events occurs:

- Birth.
- Legal adoption.
- Placement for adoption.
- Marriage.

A special enrollment period also applies for an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period if the following are true:

- The Eligible Person previously declined coverage under the Policy, but the Eligible Person and/or Dependent becomes eligible for a premium assistance subsidy under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date of determination of subsidy eligibility.
- The Eligible Person and/or Dependent had existing health coverage under another plan at the time they had an opportunity to enroll during the Initial Enrollment Period or Open Enrollment Period; and
- Coverage under the prior plan ended because of any of the following:
 - Loss of eligibility (including legal separation, divorce or death).
 - The employer stopped paying the contributions. This is true even if the Eligible Person and/or Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer.
 - In the case of COBRA continuation coverage, the coverage ended.
 - The Eligible Person and/or Dependent no longer lives or works in an HMO service area if no other benefit option is available.
 - The plan no longer offers benefits to a class of individuals that include the Eligible Person and/or Dependent.
 - An Eligible Person and/or Dependent incurs a claim that would exceed a lifetime limit on all benefits.
 - The Eligible Person and/or Dependent loses eligibility under *Medicaid* or *Children's Health Insurance Program (CHIP)*. Coverage will begin only if we receive the completed enrollment form and any required Premium within 60 days of the date coverage ended.

When an event takes place (for example, a birth, marriage or determination of eligibility for state subsidy), coverage begins on the date of the event if we receive the completed enrollment form and any required Premium within 31 days of the event unless otherwise noted above.

For an Eligible Person and/or Dependent who did not enroll during the Initial Enrollment Period or Open Enrollment Period because they had existing health coverage under another plan, coverage begins on the day immediately following the day coverage under the prior plan ends. Except as otherwise noted above, coverage will begin only if we receive the completed enrollment form and any required Premium within 31 days of the date coverage under the prior plan ended.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Benefit plan and/or all similar benefit plans at any time for the reasons explained in the Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Subscriber's coverage ends.

If you believe that your coverage ended due to health status or health care requirements, you may appeal as described in *Questions, Complaints or Appeals* or to the *Superintendent of Insurance* at the following address:

Office of the Superintendent of Insurance

Post Office Box 1689

Santa Fe, New Mexico 87504-1269

1-855-4ASK-OSI

(1-855-427-5674)

Please note that for Covered Persons who are subject to the *Extended Coverage for Total Disability* provision later in this section, entitlement to Benefits ends as described in that section.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date the Policy ends. In the event the entire Policy ends, the Enrolling Group is responsible for notifying you that your coverage has ended.

- **You Are No Longer Eligible**

Your coverage ends on the last day of the calendar month in which you are no longer eligible to be a Subscriber or Enrolled Dependent. Please refer to *Section 9: Defined Terms* for complete definitions of the terms "Eligible Person," "Subscriber," "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

Your coverage ends on the last day of the calendar month in which we receive written notice from the Enrolling Group instructing us to end your coverage, or the date requested in the notice, if later. The Enrolling Group is responsible for providing written notice to us to end your coverage.

- **Subscriber Retires or Is Pensioned**

Your coverage ends the last day of the calendar month in which the Subscriber is retired or receiving benefits under the Enrolling Group's pension or retirement plan. The Enrolling Group is responsible for providing written notice to us to end your coverage.

This provision applies unless a specific coverage classification is designated for retired or pensioned persons in the Enrolling Group's application, and only if the Subscriber continues to meet any applicable eligibility requirements. The Enrolling Group can provide you with specific information about what coverage is available for retirees.

Other Events Ending Your Coverage

When either of the following happens, we will provide advance written notice to the Subscriber that coverage will end on the date we identify in the notice:

- **Fraud or Intentional Misrepresentation of a Material Fact**

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include false information relating to another person's eligibility or status as a Dependent.

During the first two years the Policy is in effect, we have the right to demand that you pay back Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy. After the first two years, we can only demand that you pay back these Benefits if the written application contained a fraudulent misstatement.

- **Threatening Behavior**

You committed acts of physical or verbal abuse that pose a threat to our staff.

Coverage for a Disabled Dependent Child

Coverage for an Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Subscriber for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of the Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year after a two year period following the date the child attained the limiting age.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Extended Coverage for Total Disability

Coverage for a Covered Person who is Totally Disabled on the date the entire Policy is terminated will not end automatically. We will temporarily extend the coverage, only for treatment of the condition causing the Total Disability. Benefits will be paid until the earlier of either of the following:

- The Total Disability ends.
- Twelve months from the date coverage would have ended when the entire Policy was terminated.

Continuation of Coverage and Conversion

If your coverage ends under the Policy, you may be entitled to elect continuation coverage (coverage that continues on in some form) in accordance with federal or state law.

Continuation coverage under COBRA (the federal Consolidated Omnibus Budget Reconciliation Act) is available only to Enrolling Groups that are subject to the terms of COBRA. You can contact your plan administrator to determine if your Enrolling Group is subject to the provisions of COBRA.

If you selected continuation coverage under a prior plan which was then replaced by coverage under the Policy, continuation coverage will end as scheduled under the prior plan or in accordance with federal or state law, whichever is earlier.

We are not the Enrolling Group's designated "plan administrator" as that term is used in federal law, and we do not assume any responsibilities of a "plan administrator" according to federal law.

We are not obligated to provide continuation coverage to you if the Enrolling Group or its plan administrator fails to perform its responsibilities under federal law. Examples of the responsibilities of the Enrolling Group or its plan administrator are:

- Notifying you in a timely manner of the right to elect continuation coverage.
- Notifying us in a timely manner of your election of continuation coverage.

Qualifying Events for Continuation Coverage under State Law

Coverage must have ended due to one of the following qualifying events:

- Termination of the Subscriber from employment with the Enrolling Group for any reason except gross misconduct.
- Termination of coverage due to loss of eligibility as a Subscriber or an Enrolled Dependent.

Notification Requirements and Election Period for Continuation Coverage under State Law

You must elect continuation coverage within 30 days of the date you are no longer eligible. You should obtain an election form from the Enrolling Group or the employer and, once election is made, forward all monthly Premiums to the Enrolling Group for payment to us.

Terminating Events for Continuation Coverage under State Law

Continuation coverage under the Policy will end on the earliest of the following dates:

- 6 months from the date your continuation began.
- The date coverage ends for failure to make timely payment of the Premium.
- The date coverage ends because you violate a material condition of the Policy.
- The date coverage is or could be obtained under any other group health plan.
- The date the Policy ends.

Conversion

If your coverage terminates for one of the reasons described below, you may apply for conversion coverage without furnishing evidence of insurability.

Reasons for termination:

- The Subscriber is retired or pensioned.
- You cease to be eligible as a Subscriber or Enrolled Dependent.
- Continuation coverage ends.
- The entire Policy ends and is not replaced.

We will notify you in writing of your right to conversion or have the Enrolling Group do so on our behalf. Application and payment of the initial Premium must be made within 31 days after coverage ends under the

Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage may be substantially different from coverage provided under the Policy.

Conversion is not available if your coverage terminated for any of the following reasons:

- Nonpayment of any required contribution or Premium.
- Non-renewal of the Policy.
- Expiration of the term for which the Policy was issued.

Special Circumstances:

- If you are eligible for Medicare or any other similar federal or state health insurance program, your right to conversion is limited to coverage under a Medicare supplemental insurance policy.
- If the conversion policy is issued to the spouse of the Subscriber, the spouse may include coverage for Dependent children for whom the spouse has responsibility for care and support.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive Covered Health Services from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within one year of the date of service, Benefits for that health service will be denied or reduced. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Subscriber's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card.

Notice provided to us or our authorized agent, by you, or on your behalf, which includes information sufficient to identify you, shall be deemed notice to us.

Payment of Benefits

We will pay Benefits immediately after we receive your request for payment that contains all of the required information.

You may not assign your Benefits under the Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Subscriber) for you to reimburse them upon receipt of their bill. We may, however, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under the Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.

- The Covered Health Services were medically appropriate.

In the event of the Subscriber's death or incapacity, and the absence of written evidence to us of the qualification of a guardian for the Subscriber's estate, we may make any and all payments of Benefits under the Policy to the individual or institution that, in our opinion, is or was providing the Subscriber's care and support.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint. We will notify you of our decision regarding your complaint within 60 days of receiving it.

Introduction to Grievance Procedures

There are two different procedures depending on the type of issue involved: An administrative grievance and an adverse determination grievance.

An "administrative grievance" is an oral or written complaint submitted by or on behalf of a Covered Person regarding any aspect of the Enrolling Group benefit plan other than a request for health care services, including but not limited to:

- Administrative practices that affect the availability, delivery, or quality of health care services.
- Claim payment, handling or reimbursement for Health care services.
- Termination of coverage.

An "adverse determination" means a decision made either pre-service or post-service by us that a health care service requested by a provider or Covered Person has been reviewed and, based upon the information available, does not meet our requirements for coverage or medical necessity, and the requested health care service is therefore denied, reduced or terminated.

An "adverse determination grievance" is an oral or written complaint submitted by or on behalf of a Covered Person regarding an adverse determination.

Upon receipt of the grievance we will determine what type of grievance it is and follow the applicable process for that grievance as described below.

We, along with the *Superintendent of Insurance*, independent co-hearing officers and all others who have access to identifiable medical records and information of a Covered Person while reviewing a grievance, will treat and maintain such records and information as confidential, except as provided for by federal law and/or New Mexico law. We and the *Superintendent of Insurance* will establish procedures to ensure that such records and information are treated as confidential.

Initial Determination

When we receive a request to certify health care services from a provider or Covered Person, we shall determine whether the requested health care service is covered.

Before we deny a request for health care services for lack of coverage, we will determine if the health care service can be covered under any other provision. If it is determined that the health care service cannot be covered under any other provision, we need not address the issue of medical necessity.

If it is determined that the health care service is covered, we then determine if the health care service is Medically Necessary. Before we deny a request for health care services for a lack of medical necessity, a physician shall

render an option as to medical necessity, wither after consultation with specialist who are experts in the area that is the subject of review, or after application of uniform standards used by us. The physician shall be under the clinical authority of the medical director responsible for health care services provided to Covered Persons.

We will make our initial certification or adverse determination decision based on the medical exigencies of the case. We will make our decision within 24 hours of the written or verbal receipt of the request for an expedited decision whenever:

- Your life or health or the ability to regain maximum function may be jeopardized.
- The provider reasonably requests an expedited review.
- The medical exigencies of the case require an expedited review.

We will make all other initial utilization management decisions within 5 worked days. We may take up to 10 working days if we:

- Demonstrate reasonable cause beyond our control for the delay.
- Demonstrate the delay will not result in an increased medical risk to the Covered Person.
- Provide a written progress report and explanation for the delay to the Covered Person and the provider within the initial 5 working day review period.

We will notify you and the provider by written or electronic communication within 2 workings days from the date the health care service was certified, unless earlier notice is required due to the medical exigencies of the case.

We will notify you and the provider of an adverse determine by telephone within 24 hours after making the adverse determination. Additionally, we will notify you and the provider by written or electronic communication within 1 working day of the telephone notification. The notice shall:

- Clearly and completely explain why the requested health care service is not Medically Necessary when the adverse determination is based on a lack of medical necessity.
- Clearly and completely explain why the requested health care service is not covered by any provision and identify all the provisions that we relied on in making the adverse determination based on a lack of coverage.
- Advise you that you may request an internal review of our adverse determination and provide you with a description of the procedures and all forms required to be completed.

The Administrative Grievance Process

If you are dissatisfied with an administrative decision, action or inaction, including termination of coverage, you are entitled to request an internal review of an administrative grievance, either orally or in writing.

- The first level of internal review will be done by one of our representatives who are authorized to take corrective action and allow you to present any information pertinent to the administrative grievance. We will send you a written acknowledgement that we have received your administrative grievance within 3 working days. The written acknowledgement will include the name, address and direct telephone number of an individual representative of ours who may be contacted regarding the administrative grievance.
- We will mail a written decision to you within 15 working days of receipt of the administrative grievance. If there is a delay in obtaining documents or records necessary for the review of your administrative grievance the time period for our decision may be extended. If we require an extension we will notify you in writing and include the reasons the extension is required and also provide the expected date of resolution. The time period for our decision may also be extended by a mutual written agreement between you and us.

The written decision will contain:

- The name, title, and qualifications of the person conducting the initial review.
- A statement of the reviewer's understanding of the administrative grievance and all pertinent facts.
- An clear and complete explanation of:
 - ◆ The reasoning for the reviewer's decision.
 - ◆ The health benefit plan provisions relied upon in reaching the decision.
 - ◆ Any documentation or evidence considered by the reviewer in reaching the decision.

- A statement that the initial decision will be binding unless you submit a request for reconsideration within 20 working days of receipt of the initial decision.
- A description of the procedures and deadlines for requesting reconsideration of the initial decision, including any necessary forms.
- If you are dissatisfied with the results of the first level of internal review, you can request that the administrative grievance be reconsidered by an internal review committee. This committee will contain one or more employees who have not participated in the initial decision. We may include one or more Covered Persons who were not involved in the initial decision.
- The reconsideration committee will schedule and hold a hearing within 15 working days after receipt for reconsideration. The hearing will be held during regular business hours at a location reasonably accessible to you, and we will offer you the opportunity to communicate with the committee, at our expense, by conference call, video conferencing, or other appropriate technology. We will not unreasonably deny a request for postponement of the hearing made by you.
- We will notify you in writing of the hearing date, time and place at least 10 working days in advance. The notice will advise you of the rights specified below. If we have an attorney represent our interests, the notice will advise you that we will be represented by an attorney and that you may wish to obtain legal representation of your own.
- No fewer than three working days prior to the hearing, we will provide you with all documents and information that the committee will rely on in reviewing the case.
- You have the right to:
 - Attend the reconsideration committee hearing.
 - Present your case to the reconsideration committee.
 - Submit supporting material both before and at the reconsideration committee hearing.
 - Ask questions of any of our representatives.
 - Be assisted or represented by a person of your choice.

Decision of the Reconsideration Committee

We will mail a written decision to you within seven working days after the reconsideration committee hearing. The written decision will include:

- The name, titles, and qualifications of the persons on the reconsideration committee.
- The reconsideration committee's statement of the issues involved in the administrative grievance.
- A clear and complete explanation of the rationale for the reconsideration committee's decision.
- A statement that the initial decision will be binding unless you submit a request for external review by the *Superintendent* within 20 working days of receipt of the reconsideration decision.
- A description of the procedures and deadlines for requesting external review by the *Superintendent*, including any necessary forms. The notice will contain the toll-free telephone number and address of the *Superintendent's* office.

External Review of Grievances by the New Mexico Superintendent of Insurance

Every grievant who is dissatisfied with the results of the internal review of an administrative decision will have the right to request external review by the *Superintendent of Insurance*. The *Superintendent of Insurance* may require you to exhaust the grievance procedures adopted by us, as appropriate, before accepting a grievance for external review.

To initiate an external review, you must file a written request for external review with the *Superintendent of Insurance* within 20 working days from the receipt of the written notice of reconsideration decision. If you wish to supply supporting documents or information subsequent to filing the request for external review, the timeframes for external review will be extended up to 90 days from receipt of the complaint form, or until you submit all supporting documentation, whichever comes first.

The request must be submitted using one of the following methods:

- Mailed to the *Superintendent of Insurance* at:
Attn: Managed Health Care Bureau - External Review Request, New Mexico *Superintendent of Insurance*,
Post Office Box 1689, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1689.
- Emailed to mhcb.grievance@state.nm.us, subject External Review Request.
- Faxed to the *Superintendent of Insurance* Attn: Managed Care Health Bureau - External Review Request, at (505) 827-3833.
- Completed on-line with a *NM OSI, New Mexico Office of Superintendent of Insurance* complaint form available at <http://www.OSI.state.nm.us>.

If required by the medical urgency of the case, a Covered Person or provider may request an expedited review by telephone to the *Managed Health Care Bureau* at (505) 827-4601 or 1-855-427-5674.

You will need to provide a copy of the grievance decision from us, a fully executed release form authorizing the *Superintendent of Insurance* to obtain any necessary medical records from us or any other relevant provider, if the grievance involves an experimental or investigational treatment adverse determination, the provider's certification and recommendation and any other supporting documents or information you may want to submit for review.

Upon receipt of a request for external review the *Superintendent of Insurance* shall immediately send:

- An acknowledgment of receipt of the request for external review to you.
- A copy of the request for external review to us.

Upon receipt of the copy of the request for external review we will provide the documents and information considered in making the administrative grievance decision within 5 working days to you and the *Superintendent of Insurance*.

The *Superintendent of Insurance* will review the documents and information submitted by you and by us and may conduct an investigation or inquiry or consult with you, as appropriate. The Superintendent of Insurance will issue a written decision on the administrative grievance within 20 working days from receipt of the completed request or external review.

The Adverse Determination Grievance Process

How to Request an Internal Review of an Adverse Determination

Every grievant who is dissatisfied with an adverse determination has the right to request an internal review of the adverse determination. If you informally contact *Customer Care* first and later wish to submit a formal grievance, you may contact *Customer Care* and a representative will assist you in preparing a formal grievance.

Your request for a grievance should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your grievance must be submitted to us within 180 days after you receive the denial of a pre-service request for Benefits for the post-service denial. If you are requesting an expedited review of an adverse determination please see *Expedited Review of an Adverse Determination* below.

The Internal Review of an Adverse Determination Process

We will send you a written acknowledgement that we have received your request for review of the adverse determination within 1 working day. We will date and time stamp the request when we receive it. The written acknowledgement will include the name, address and direct telephone number of an individual representative of ours who may be contacted regarding the request.

When we receive your request for review of the adverse determination we will conduct either a standard or expedited review, as appropriate.

If your grievance is related to clinical matters, the medical director or an appropriate person designated by the medical director will complete his or her review of the adverse determination within the timeframes required by the medical exigencies of the case. We may consult with, or seek the participation of, medical experts as part of the grievance resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

If the adverse determination was based on a lack of medical necessity, the medical director shall render an opinion as to medical necessity, either after consultation with specialist who are experts in the area that is the subject of the review, or after application of uniform standards used by us.

The internal review of an adverse determination (first level) will be decided by our medical director or by an appropriate person designated by the medical director. That person will determine if the health care service can be covered under any provision. If the medical director reverses the initial adverse determination and certifies the health care service, we will notify you and your provider. If the medical director upholds the initial adverse determination to deny the requested health care service, you and your provider will be notified of our decision by telephone or in writing. If we are unable to contact you by telephone within 72 hours of making the decision to uphold the determination, we will notify you by mail of the medical director's decision and will include in the notification a self-addressed stamped response form asking you whether you wish to pursue the grievance further. If you do not return the response form within ten working days, we will contact you by telephone to confirm whether you wish to pursue the grievance further. If you do not respond to our telephone inquires or return the response form, for standard reviews we will close the file if we can document our efforts to contact you and you have not responded within 20 working days. For expedited reviews, we will select a medical panel to further review the adverse determination. If you do not make an immediate decision to pursue the grievance or you request additional time to supply supporting documentation or information, the timeframes described above shall be extended to include the additional time you require. If you respond that you do not wish to pursue the grievance, we will mail you a written notification of the medical director's decision and a confirmation of your decision to not peruse the matter further within 3 working days from the date of the medical director's decision or within 3 working days from the date we receive your response.

If you are not satisfied with the first level determination, you have the right to request an internal panel review of an adverse determination (second level). Your second level request must be submitted to us within 20 days from the receipt of the first level determination, however, we will not unreasonably deny a request for postponement of the internal panel review that you make. The timeframes for the internal panel review shall be extended during the period of any postponement agreed upon. The internal review panel will contain one or more of our representatives and one or more health care professional who were not previously involved in the adverse determination of your grievance. At least one of the health care professionals selected shall practice in a specialty that would typically manage the case that is the subject of the grievance, or be mutually agreed upon by you and us. Internal panel members must be physically present or present via telephone or video conferencing to hear the grievance or they shall not participate in the panel. The internal panel will determine if the health care service can be covered under any provision or the internal panel will render an opinion as to medical necessity, either after consultation with specialist who are experts in the area that is the subject of the review, or after application of uniform standards used by us. The internal panel will notify you if we are represented by an attorney and advise you that you may wish to obtain legal representation as well. You will be notified of the decision by telephone within 24 hours of the panel's decision and in writing or by electronic means within 1 working day of the telephone notice. The written notice shall contain:

- The names, titles and qualifying credentials of the persons on the internal review panel.
- A statement of the internal review panel's understanding of the nature of the grievance and all pertinent facts.
- A clear and complete explanation of the rationale for the internal review panel's decision.

- A explanation as to why each provision did or did not support the internal review panel's decision regarding coverage.
- Citations to the uniform standards relevant to your medical condition and explain whether each supported or did not support the internal review panel's decision regarding medical necessity of the requested health care service.
- References to any other evidence or documentation considered by the internal review panel in making its decision.
- Notice of your right to request an external review by the *Superintendent of Insurance*, including the address and telephone number of the *Managed Health Care Bureau* of the *Superintendent of Insurance*, a description of all procedures and time deadlines necessary to pursue an external review and copied of any forms required to initiate the external review.

With regard to the second level request, you have the right to:

- Attend and participate in the internal panel review hearing.
- Present your case to the review committee.
- Submit supporting material both before and at the review hearing.
- Ask questions of any of our representatives.
- Ask questions of any health professionals on the internal panel.
- Be assisted or represented by a person of your choice, including legal representation.
- Hire a specialist to participate in the internal panel review at his or her own expense, but such specialist may not participate in making the decision.

Within three working days prior to the internal panel review, we will provide you copies of:

- The Covered Person's pertinent medical records.
- The treating provider's recommendation.
- The Covered Person's health benefit plan.
- Our notice of adverse determination.
- Uniform standards relevant to the grievant's medical condition that is used by the internal panel in reviewing the adverse determination.
- Questions sent to or reports received from any medical consultants retained by us.
- All other evidence or documentation relevant to reviewing the adverse determination.

For grievances relating to pre-service requests for Benefits, both the internal review and internal panel review (as applicable) will be completed within 20 working days from receipt of a request a grievance that contains all of the information you wish the committee to review. For grievances relating to post-service determination, both the internal review and internal panel review (as applicable) will be completed within 40 days from receipt of a grievance for Benefits or claim that contains all the information you wish the committee to review.

We may extended the review for a maximum of 10 working days for pre-service request, and a maximum of 20 working days for post-service requests if we:

- Demonstrate reasonable cause beyond our control for the delay.
- Demonstrate the delay will not result in an increased medical risk to the Covered Person.
- Provide a written progress report and explanation for the delay to the Covered Person and the provider within the original 30 day time frame for pre-service or 60 day time frame for post-service requests.

If the grievance contains clearly divisible administrative and adverse decision issues, we shall separate the requests for each decision.

If we fail to meet the deadlines described above the requested health service shall be deemed approved unless you, after being fully informed of your rights, agreed in writing to extend the deadline.

Expedited Review of an Adverse Determination

Your adverse determination grievance may require immediate action if a delay in treatment could jeopardize your life or health, or the ability to regain maximum function. In these urgent situations:

- The request does not need to be submitted in writing. You or your Physician should call us as soon as reasonably possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

The process for urgent situations does not apply to prescheduled treatments, therapies or surgeries.

During an expedited review we will communicate with you in the most expeditious manner available. If the expedited review is conducted during an Inpatient Hospital Stay or course of treatment, Benefits shall be continued without cost (except for applicable Copayments, Coinsurance or deductibles) until we make a final decision and notify you.

We shall not conduct an expedited review of an adverse determination made after health care services have been provided to you.

External Review of Grievances by the New Mexico Superintendent of Insurance

Every grievant who is dissatisfied with the results of the medical panel review of an adverse determination grievance may request external review by the *Superintendent of Insurance*. The *Superintendent of Insurance* may require you to exhaust the grievance procedures adopted by us, as appropriate, before accepting a grievance for external review.

To initiate an external review, you must file a written request for external review with the *Superintendent of Insurance* within 20 working days from the receipt of the written notice of internal review decision unless extended by the *Superintendent* for good cause shown.

The request must be submitted using one of the following methods:

- Mailed to the *Superintendent of Insurance* at:
Attn: Managed Health Care Bureau - External Review Request, New Mexico Superintendent of Insurance,
Post Office Box 1689, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1689.
- Emailed to mhcb.grievance@state.nm.us, subject External Review Request.
- Faxed to the *Superintendent of Insurance* Attn: Managed Care Health Bureau - External Review Request, at (505) 827-3833.
- Completed on-line with a *NM OSI, New Mexico Office of Superintendent of Insurance* complaint form available at <http://www.OSI.state.nm.us>.

If required by the medical urgency of the case, a Covered Person or provider may request an expedited review by telephone to the *Managed Health Care Bureau* at (505) 827-4601 or 1-855-427-5674.

You will need to provide a copy of the grievance decision from us, a fully executed release form authorizing the Superintendent of Insurance to obtain any necessary medical records from us or any other relevant provider, if the grievance involves an experimental or investigational treatment adverse determination, the provider's certification and recommendation and any other supporting documents or information you may want to submit for review.

Upon receipt of a request for external review the *Superintendent of Insurance* shall immediately send:

- An acknowledgment of receipt of the request for external review to you.
- A copy of the request for external review to us.

Upon receipt of the copy of the request for external review we will provide the following within 5 working days to you and the *Superintendent of Insurance*:

- A summary of benefits.
- The complete health benefits plan, which may be in the form of a member handbook/certificate of coverage.
- All pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by you and/or by us.
- Uniform standards relevant to your medical condition that were used by the internal review panel in reviewing the adverse determination.
- Any other documents, records and information relevant to the adverse determination and the internal review decision or intended to be relied on at the external review hearing.

If we fail to comply with these requirements, the *Superintendent of Insurance* may reverse the adverse determination.

The *Superintendent of Insurance* may waive these requirements if necessitated by the medical exigencies of the case.

- The *Superintendent of Insurance* will conduct either a standard or expedited external review of the adverse determination as required by the medical exigencies of the case.
 - For an expedited review, the *Superintendent of Insurance* shall complete an external review no later than 72 hours from receipt of the external review request when a delay in treatment could jeopardize your life or health, or the ability to regain maximum function.
 - For a standard review, the *Superintendent of Insurance* shall conduct the initial review within 10 working days from receipt of the request for an external review and all required information for you and us.

If a hearing is held, the *Superintendent of Insurance* shall complete the external review within 30 working days from receipt of the complete request for external review. The *Superintendent of Insurance* may extend the external review period for up to an additional 10 working days when the *Superintendent of Insurance* has been unable to schedule the hearing within the required timeframe and the delay will not result in an increased medical risk to you.

If you wish to supply supporting documentation or information subsequent to the filing of the request for an external review, the timeframes noted above shall be extended up to 90 days from the receipt of the complaint form, or until you submit all supporting documents, whichever occurs first.

Upon receipt of a request for external review, *Superintendent of Insurance* staff shall review the request to determine:

- If you have provided all of the required documents.
- That you are or were a Covered Person of ours at the time the health care service was requested or provided.
- That you have exhausted our internal review procedures and any applicable grievance review procedure of an entity that purchases or is authorized to purchase health care benefits pursuant to the *New Mexico Health Care Purchasing Act*.
- The health care service that is the subject of the grievance reasonably appears to be a covered benefit under your plan.
- If the external review request is for an experimental or investigational treatment adverse determination with regards to coverage, *Superintendent of Insurance* staff shall also consider whether the recommended or requested health care service:
- Reasonably appears to be a covered benefit under your plan except for our determination that the health care service is experimental or investigational for a particular medical condition.
- Is not explicitly listed as an excluded benefit.

If the external review request is for an experimental or investigational treatment adverse determination with regards to medical necessity, *Superintendent of Insurance* staff shall also consider if your provider has certified that:

- Standard health care services have not been effective in improving your condition.
- Standard health care services are not medically appropriate for you.

- There is no standard health care service covered by us that is as beneficial or more beneficial than the health care service:
 - Recommended by your treating provider that the treating provider certifies in writing is likely to be more beneficial to the covered person, in the treating provider's opinion, than standard health care services.
 - Requested by you regarding which the your treating provider, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service requested by you is likely to be more beneficial to you than available standard health care services.

If the *Superintendent of Insurance* staff determines that the request is incomplete, they shall immediately notice you and require you to submit the required information within a specified period of time.

If the *Superintendent of Insurance* staff determines that the request does not meet the required criteria, they shall inform the *Superintendent of Insurance*. The *Superintendent of Insurance* shall notify you and us that the request does not meet the criteria for an external review and is therefore denied, and that you have the right to request a hearing, following the hearing procedures, within 33 days from the date the notice was mailed.

If the *Superintendent of Insurance* staff determines that the request meets the criteria for an external review, they shall inform the *Superintendent of Insurance*. The *Superintendent of Insurance* shall notify you and us that the request meets the criteria for an external review and that an informal hearing has been set to determine whether, as a result of the our adverse determination, you were deprived of Medically Necessary covered services. Prior to the hearing, *Superintendent of Insurance* staff shall attempt to informally resolve the grievance. The notice of hearing shall be mailed no later than 8 working days prior to the hearing date. The notice shall state the date, time and place of the hearing and the matters to be considered and also shall advise you and us of the rights afford to us by law. The *Superintendent of Insurance* shall not unreasonably deny a request for postponement of the hearing made by you or us.

Hearing Procedures

If a hearing is held, the *Superintendent of Insurance* may designate a hearing officer who shall be an attorney licensed in New Mexico. The hearing may be conducted by telephone conference call, video conferencing or other appropriate technology at the *Superintendent of Insurance* expense.

The *Superintendent of Insurance* may designate 2 independent co-hearing officers who shall be licensed health care professionals. If the *Superintendent of Insurance* designates 2 independent co-hearing officers, at least one of them shall practice a specialty that would typically manage the case that is the subject of the grievance.

The *Superintendent of Insurance* or hearing officer shall regulate the hearing and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The *Superintendent of Insurance* or hearing officer may:

- Require the production of additional records, documents and writings relevant to the subject of the grievance.
- Exclude any irrelevant, immaterial or unduly repetitious evidence.
- Proceed with the hearing or adjourn the proceedings to a future date if you or we fail to appear. The *Superintendent of Insurance* or hearing officer will provide notice of the adjournment to the absent party.

Superintendent of Insurance staff may attend the hearing, ask questions and otherwise solicit evidence from the parties, but shall not be present during any deliberations.

The *Superintendent of Insurance* or hearing officer may call and examine you, us and any other witnesses. All testimony given at the hearing shall be taken under oath.

The hearing shall be stenographically recorded at the *Superintendent of Insurance* expense.

Both you and we have the right to:

- Attend the hearing. We shall designate a person or persons to attend on our behalf and you may designate a person or persons to attend on your behalf if you choose to not attend personally.
- Be assisted or represented by an attorney or other person.
- Call, examine and cross-examine witnesses.

Both you and we shall stipulate on the record that the hearing officers shall be released from civil liability for all communications, findings, opinions and conclusions made in the course and scope of the external review.

At the close of the hearing, the hearing officers shall review and consider the entire record and prepare findings of fact, conclusions of law and a recommended decision. Any hearing officer may submit a supplementary or dissenting option to the recommended decision.

Within the above time frame, the *Superintendent of Insurance* shall issue an appropriate order. If the order requires action on our part, the order shall specify the timeframe for us to comply with the order. The order shall be binding on you and us and shall state that you and we have the right to judicial review and that state and federal law may provide other remedies. Neither you or we may file a subsequent request for an external review for the same adverse determination.

Independent Co-Hearing Officers

The *Superintendent of Insurance* shall consult with appropriate professional societies, organizations, or associations to identify licensed health care and other professional who are willing to service as independent co-hearing officers in external reviews.

Prior to accepting designation as an independent co-hearing officer, each potential independent co-hearing officer shall provide to the *Superintendent of Insurance* a list identifying all health care insurers and providers with whom they maintain any health care related or other professional business arrangements and a brief explanation of the nature of each arrangement. Each independent co-hearing officer shall disclose to the *Superintendent of Insurance* any other potential conflict of interest that may arise in hearing a particular case, including any personal or professional relationship to you or to us or to providers involved in a particular external review.

The *Superintendent of Insurance* shall consult with appropriate professional societies, organizations, or associations in New Mexico to determine reasonable compensation for appointed independent co-hearing officers for external grievance reviews and shall annually publish a schedule of independent co-hearing compensation in a bulletin.

Upon completion of an external review, that hearing officer and co-hearing officers shall each complete a state of independent co-hearing officer compensation form prescribed by the *Superintendent of Insurance*, detailing the amount of time spent participating in the external review and submit it to the *Superintendent of Insurance* for approval. The *Superintendent of Insurance* shall send the approved statement of independent co-hearing compensation to the us. Within 30 days of the receipt of the statement, we shall remit the approved compensation directly to the independent co-hearing officer. If the parties provider written notice of a settlement, up to 3 working days prior to the date of the hearing, compensation will not be made to the hearing officers or independent co-hearing officers.

Section 7: Coordination of Benefits

Benefits When You Have Coverage under More than One Plan

This section describes how Benefits under the Policy will be coordinated with those of any other plan that provides benefits to you. The language in this section is from model laws drafted by the *National Association of Insurance Commissioners (NAIC)* and represents standard industry practice for coordinating benefits.

When Coordination of Benefits Applies

This coordination of benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules below govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

For purposes of this section, terms are defined as follows:

- A. A Plan is any of the following that provides benefits or services for medical, pharmacy or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
 - 1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.
 - 2. Plan does not include: hospital indemnity coverage insurance or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.
- Each contract for coverage under 1. or 2. above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
- B. This Plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from This Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
 - C. The order of benefit determination rules determine whether This Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one Plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable Expense.
 - D. Allowable Expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expenses:

1. The difference between the cost of a semi-private hospital room and a private room is not an Allowable Expense unless one of the Plans provides coverage for private hospital room expenses.
 2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
 3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
 4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine its benefits.
 5. The amount of any benefit reduction by the Primary Plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions and preferred provider arrangements.
- E. Closed Panel Plan is a Plan that provides health care benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- F. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

- A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.
- B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
- C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.
- D. Each Plan determines its order of benefits using the first of the following rules that apply:
 1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent

(e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

2. **Dependent Child Covered Under More Than One Coverage Plan.** Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
 - (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.
 - b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
 - (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.
 - (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.
 - (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - (a) The Plan covering the Custodial Parent.
 - (b) The Plan covering the Custodial Parent's spouse.
 - (c) The Plan covering the non-Custodial Parent.
 - (d) The Plan covering the non-Custodial Parent's spouse.
 - c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.
3. **Active Employee or Retired or Laid-off Employee.** The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.
4. **COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits,

this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.
6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

Effect on the Benefits of This Plan

- A. When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.
- B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.
- C. This Coverage Plan reduces its benefits as described below for Covered Persons who are eligible for Medicare when Medicare would be the Primary Coverage Plan.

Medicare benefits are determined as if the full amount that would have been payable under Medicare was actually paid under Medicare, even if:

- The person is entitled but not enrolled in Medicare. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.
- The person is enrolled in a *Medicare Advantage* (Medicare Part C) plan and receives noncovered services because the person did not follow all rules of that plan. Medicare benefits are determined as if the services were covered under Medicare Parts A and B.
- The person receives services from a provider who has elected to opt-out of Medicare. Medicare benefits are determined as if the services were covered under Medicare Parts A and B and the provider had agreed to limit charges to the amount of charges allowed under Medicare rules.
- The services are provided in any facility that is not eligible for Medicare reimbursements, including a Veterans Administration facility, facility of the Uniformed Services, or other facility of the federal government. Medicare benefits are determined as if the services were provided by a facility that is eligible for reimbursement under Medicare.
- The person is enrolled under a plan with a *Medicare Medical Savings Account*. Medicare benefits are determined as if the person were covered under Medicare Parts A and B.

If you are eligible for, but not enrolled in Medicare, and this Coverage Plan is secondary to Medicare, or if you have enrolled in Medicare but choose to obtain services from a provider that does not participate in the Medicare program, Benefits will be paid on a secondary basis under this Coverage Plan and will be determined as if you timely enrolled in Medicare and obtained services from a Medicare participating provider. When calculating this Coverage Plan's secondary Benefits in these circumstances, for administrative convenience we may treat the provider's billed charges as the Allowable Expense for both this Coverage Plan and Medicare, rather than the Medicare approved amount or Medicare limiting charge.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other Plans. We may get the facts we need from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under This Plan and other Plans covering the person claiming benefits.

We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give us any facts we need to apply those rules and determine benefits payable. If you do not provide us the information we need to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Payments Made

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, we may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments we made is more than we should have paid under this COB provision, we may recover the excess from one or more of the persons we have paid or for whom we have paid; or any other person or organization that may be responsible for the benefits or services provided for you. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

When Medicare is Secondary

If you have other health insurance which is determined to be primary to Medicare, then Benefits payable under This Plan will be based on Medicare's reduced benefits. In no event will the combined benefits paid under these coverages exceed the total Medicare Eligible Expense for the service or item.

Section 8: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Enrolling Group's Benefit plan and how it may affect you. We help finance or administer the Enrolling Group's Benefit plan in which you are enrolled. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Enrolling Group's Benefit plan will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this *Certificate*.
- The plan may not pay for all treatments you or your Physician may believe are necessary. If the plan does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers and Enrolling Groups

The relationships between us and Network providers and Enrolling Groups are solely contractual relationships between independent contractors. Network providers and Enrolling Groups are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers or the Enrolling Groups.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

We are not considered to be an employer for any purpose with respect to the administration or provision of benefits under the Enrolling Group's Benefit plan. We are not responsible for fulfilling any duties or obligations of an employer with respect to the Enrolling Group's Benefit plan.

The Enrolling Group is solely responsible for all of the following:

- Enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage).
- The timely payment of the Policy Charge to us.
- Notifying you of the termination of the Policy.

When the Enrolling Group purchases the Policy to provide coverage under a benefit plan governed by the *Employee Retirement Income Security Act* ("ERISA"), 29 U.S.C. § 1001 et seq., we are not the plan administrator or named fiduciary of the benefit plan, as those terms are used in ERISA. If you have questions about your welfare benefit plan, you should contact the Enrolling Group. If you have any questions about this statement or about your rights under ERISA, contact the nearest area office of the *Employee Benefits Security Administration, U. S. Department of Labor*.

Your Relationship with Providers and Enrolling Groups

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider. You have the choice in the selection of a hospital for hospital care or of a practitioner of the healing arts or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife, or registered nurse in expanded practice.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

The relationship between you and the Enrolling Group is that of employer and employee, Dependent or other classification as defined in the Policy.

Notice

When we provide written notice regarding administration of the Policy to an authorized representative of the Enrolling Group, that notice is deemed notice to all affected Subscribers and their Enrolled Dependents. The Enrolling Group is responsible for giving notice to you.

Statements by Enrolling Group or Subscriber

All statements made by the Enrolling Group or by a Subscriber shall, in the absence of fraud, be deemed representations and not warranties. Except for fraudulent statements, we will not use any statement made by the Enrolling Group to void the Policy after it has been in force for a period of two years.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We will do all of the following:

- Interpret Benefits under the Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in the Policy, including this *Certificate*, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to the Policy and its Benefits.

Other persons or entities may provide services in regard to the administration of the Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may arrange for various persons or entities to provide administrative services in regard to the Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to the Policy

To the extent permitted by law, and in accordance with the legal requirements allowing us to do so (including any required notification), we reserve the right, without your approval, to change, interpret, modify, withdraw or add Benefits or terminate the Policy.

Any provision of the Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to the Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments to the Policy are effective 31 days after we send written notice to the Enrolling Group.
- Riders are effective on the date we specify.
- No agent has the authority to change the Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to the Policy.

Information and Records

We may use your individually identifiable health information to administer the Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under the Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of the Policy, we and our related entities may use and transfer the information gathered under the Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our *Notice of Privacy Practices*.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under the Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Medicare Eligibility

Benefits under the Policy are not intended to supplement any coverage provided by Medicare. Nevertheless, in some circumstances Covered Persons who are eligible for or enrolled in Medicare may also be enrolled under the Policy.

If you are eligible for or enrolled in Medicare, please read the following information carefully.

If you are eligible for Medicare on a primary basis (Medicare pays before Benefits under the Policy), you should enroll in and maintain coverage under both Medicare Part A and Part B. If you don't enroll and maintain that coverage, and if we are the secondary payer as described in *Section 7: Coordination of Benefits*, we will pay Benefits under the Policy as if you were covered under both Medicare Part A and Part B. As a result, you will be responsible for the costs that Medicare would have paid and you will incur a larger out-of-pocket cost.

If you are enrolled in a *Medicare Advantage* (Medicare Part C) plan on a primary basis (Medicare pays before Benefits under the Policy), you should follow all rules of that plan that require you to seek services from that plan's participating providers. When we are the secondary payer, we will pay any Benefits available to you under the Policy as if you had followed all rules of the *Medicare Advantage* plan. You will be responsible for any additional costs or reduced Benefits that result from your failure to follow these rules, and you will incur a larger out-of-pocket cost.

Reimbursement - Right To Recovery

In consideration of the coverage provided by this *Certificate*, we shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, if you make a recovery from any or all of the following listed below.

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

These third parties and persons or entities are collectively referred to as "Third Parties."

You agree as follows:

- That you will cooperate with us in protecting our reimbursement, including, but not limited to:
 - Providing any relevant information requested by us.
 - Signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim.
 - Responding to requests for information about any accident or injuries.
 - Making court appearances.
- That no court costs or attorneys' fees may be deducted from our recovery without our express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and we are not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.
- That regardless of whether you have been fully compensated or made whole, we may collect from you the benefits we have paid on your behalf from any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, with such proceeds available for collection to include any and all amounts earmarked as non-economic damage settlement or judgment.
- That benefits paid by us may also be considered to be benefits advanced.
- That you agree that if you receive any payment from any potentially responsible party as a result an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing us, stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That we may set off from any future benefits otherwise provided by us the value of benefits paid advanced under this section to the extent not recovered by us.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate and your heirs or beneficiaries.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under the Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under the Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under the Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Limitation of Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Entire Policy

The Policy issued to the Enrolling Group, including this *Certificate*, the *Schedule of Benefits*, the Enrolling Group's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 9: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance Use Disorder Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to the Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of the Policy, except for those that are specifically amended.

Annual Deductible - for Benefit plans that have an Annual Deductible, this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to payment of an Annual Deductible and for details about how the Annual Deductible applies.

Autism Spectrum Disorders - a group of neurobiological disorders that includes *Autistic Disorder, Rhetts's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder* and *Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.

Benefits - your right to payment for Covered Health Services that are available under the Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of the Policy, including this *Certificate*, the *Schedule of Benefits* and any attached Riders and/or Amendments.

Certified Nurse Midwife - any person who is licensed by the board of nursing as a registered nurse and who is licensed by the *New Mexico Department of Health* as a Certified Nurse Midwife.

Certified Nurse Practitioner - a registered nurse whose qualifications are endorsed by the board of nursing for expanded practice as a Certified Nurse Practitioner and whose name and pertinent information is entered on the list of Certified Nurse Practitioners maintained by the board of nursing.

Coinsurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this *Certificate* under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this *Certificate* under *Section 2: Exclusions and Limitations*.

Covered Person - either the Subscriber or an Enrolled Dependent, but this term applies only while the person is

enrolled under the Policy. References to "you" and "your" throughout this *Certificate* are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Subscriber's legal spouse or a child of the Subscriber or the Subscriber's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Subscriber or the Subscriber's spouse.

To be eligible for coverage under the Policy, a Dependent must reside within the United States.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Subscriber.

The Subscriber must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

A Dependent also includes a child, including a child of a non-custodial parent, for whom health care coverage is required through a *Qualified Medical Child Support Order* or other court or administrative order. The Enrolling Group is responsible for determining if an order meets the criteria of a *Qualified Medical Child Support Order*.

A Dependent does not include anyone who is also enrolled as a Subscriber. No one can be a Dependent of more than one Subscriber.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - for Benefit plans that have a Designated Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Designated Network Benefits and for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within your geographic area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use, and is primarily used, within the home.

- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while the Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - an employee of the Enrolling Group or other person whose connection with the Enrolling Group meets the eligibility requirements specified in both the application and the Policy. An Eligible Person must reside within the United States.

Emergency - a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness which is both of the following:

- Arises suddenly.
- In the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health, serious dysfunction of a bodily organ or part, or disfigurement.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency.

Enrolled Dependent - a Dependent who is properly enrolled under the Policy.

Enrolling Group - the employer, or other defined or otherwise legally established group, to whom the Policy is issued.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials in Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials in Section 1: Covered Health Services*, and Sickness or condition that is likely to cause death within one year of the request for treatment we may consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Genetic Inborn Error of Metabolism - a rare, inherited disorder that is present at birth and if left untreated results in mental retardation or death and requires consumption of Special Medical Foods.

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations,

or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution.

Initial Enrollment Period - the initial period of time during which Eligible Persons may enroll themselves and their Dependents under the Policy.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance use disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the therapeutic application of chiropractic and/or osteopathic manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medically Necessary - health care services determined by a provider, in consultation with the health care insurer for the diagnosis or direct care and treatment of a physical, behavioral or mental health condition, illness, injury or disease, that are determined to be appropriate or necessary according to applicable *Generally Accepted Standards of Medical Practice* or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practices guidelines developed by us consistent with such federal, national and professional practice guidelines for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury, or disease.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Medically necessary services are not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be made by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance Use Disorder Services for which Benefits are available under the Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under the Policy.

Mobility Device - A manual wheelchair, electric wheelchair, transfer chair or scooter.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - for Benefit plans that have a Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Network Benefits and for details about how Network Benefits apply.

Non-Network Benefits - for Benefit plans that have a Non-Network Benefit level, this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan offers Non-Network Benefits and for details about how Non-Network Benefits apply.

Open Enrollment Period - a period of time that follows the Initial Enrollment Period during which Eligible Persons may enroll themselves and Dependents under the Policy. The Enrolling Group determines the period of time that is the Open Enrollment Period.

Out-of-Pocket Maximum - for Benefit plans that have an Out-of-Pocket Maximum, this is the maximum amount you pay every year. Refer to the *Schedule of Benefits* to determine whether or not your Benefit plan is subject to an Out-of-Pocket Maximum and for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Policy.

Pharmaceutical Product List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Pharmaceutical Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Pharmaceutical Product List Management Committee - the committee that we designate for, among other responsibilities, classifying Pharmaceutical Products into specific tiers.

Physician - any *Doctor of Medicine* or *Doctor of Osteopathy* who is properly licensed and qualified by law.

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, obstetrician-gynecologist, physician's assistant, Certified Nurse Midwife, Registered Lay Midwife or Registered Nurse in Expanded Practice, Certified Nurse Practitioner, independent social worker, woman's health care provider or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under the Policy.

Policy - the entire agreement issued to the Enrolling Group that includes all of the following:

- The *Group Policy*.
- This *Certificate*.
- The *Schedule of Benefits*.
- The Enrolling Group's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Enrolling Group.

Policy Charge - the sum of the Premiums for all Subscribers and Enrolled Dependents enrolled under the Policy.

Practitioner of the Healing Arts - any person holding a license or certificate authorizing the licensee to offer or undertake to diagnose, treat, operate on or prescribe for any human pain, injury, disease, deformity or physical or mental condition pursuant to:

- The *Chiropractic Physician Practice Act*.
- The *Dental Health Care Act*.
- The *Medical Practice Act*.
- Chapter 61, Article 10 NMSA 1978.
- The *Acupuncture and Oriental Medicine Practice Act*.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Subscriber and each Enrolled Dependent, in accordance with the terms of the Policy.

Primary Physician/Primary Care Practitioner - a health care professional who, within the scope of his or her license, supervises, coordinates, and provides initial and basic care to covered persons, who initiates their referral for specialist care, and who maintains continuity of patient care. Primary care practitioners shall include but not be limited to general practitioners, family practice physicians, internists, pediatricians, and obstetricians-gynecologists, physician assistants and nurse practitioners. Other health care professionals may also provide primary care such as doctors of oriental medicine, chiropractic physicians, or certified nurse midwives who may provide primary care, provided that the health care practitioner is acting within his or her scope of practice as defined under the relevant state licensing law.

Private Duty Nursing - nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or home setting when any of the following are true:

- No skilled services are identified.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Registered Lay Midwife - any person who practices lay midwifery and is registered as a lay midwife by the *New Mexico Department of Health*.

Registered Nurse in Expanded Practice - any person licensed by the board of nursing as a registered nurse approved for expanded practice pursuant to the *Nursing Practice Act* as a Certified Nurse Practitioner, certified registered nurse anesthetist, certified clinical nurse specialist in psychiatric mental health nursing or clinical nurse specialist in private practice and who has a master's degree or doctorate in a defined clinical nursing specialty and is certified by a national nursing organization.

Residential Treatment Facility - a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Services not described in this *Certificate*. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of the Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - the Shared Savings Program provides access to discounts from the provider's charges when services are rendered by those non-Network providers that participate in that program. We will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. We do not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in Benefit plans that have both Network and Non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the Non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When we use the Shared Savings Program to pay a claim, patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required deductible.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this *Certificate* does not include Mental Illness or substance use disorders, regardless of the cause or origin of the Mental Illness or substance use disorder.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Special Medical Foods - are nutritional substances in any form that are formulated to be consumed or administered internally under the supervision of a Physician, specifically processed or formulated to be distinct in one or more nutrients present in natural food, intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation and essential to optimize growth, health and metabolic homeostasis.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Subscriber - an Eligible Person who is properly enrolled under the Policy. The Subscriber is the person (who is not a Dependent) on whose behalf the Policy is issued to the Enrolling Group.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Tertiary Care Facility - a Hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

Total Disability or Totally Disabled - a Subscriber's inability to perform all of the substantial and material duties of his or her regular employment or occupation; and a Dependent's inability to perform the normal activities of a person of like age and sex.

Transitional Care - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient

evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

UnitedHealthcare Choice Plus

UnitedHealthcare Insurance Company

Schedule of Benefits

Accessing Benefits

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network Emergency room Physician, radiologist, anesthesiologist or pathologist.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Depending on the geographic area and the service you receive, you may have access through our Shared Savings Program to non-Network providers who have agreed to discount their charges for Covered Health Services. If you receive Covered Health Services from these providers, the Coinsurance will remain the same as it is when you receive Covered Health Services from non-Network providers who have not agreed to discount their charges; however, the total that you owe may be less when you receive Covered Health Services from Shared Savings Program providers than from other non-Network providers because the Eligible Expense may be a lesser amount.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under a UnitedHealthcare Policy. As a result, they may bill you for the entire cost of the services you receive.

You have the choice in the selection of a hospital for hospital care or of a practitioner of the healing arts or optometrist, psychologist, podiatrist, physician assistant, certified nurse-midwife, registered lay midwife, or registered nurse in expanded practice.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you by the Enrolling Group, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which prior authorization is required are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a

Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to determine how far in advance you must obtain prior authorization.

- Ambulance - non-emergent air and ground.
- Clinical trials.
- Congenital heart disease surgery.
- Dental services - accidental.
- Dental Services - Hospitalization and General Anesthesia.
- Diabetes equipment - insulin pumps over \$1,000.
- Durable Medical Equipment over \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).
- Early intervention services.
- Genetic Inborn Errors of Metabolism.
- Genetic Testing - BRCA.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
- Lab, X-ray and diagnostics - sleep studies.
- Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, Nuclear Medicine and Capsule Endoscopy.
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Neurobiological disorders - Autism Spectrum Disorder services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Obesity surgery.
- Pharmaceutical Products - IV infusions only.
- Prosthetic devices over \$1,000 in cost per device.
- Reconstructive procedures, including breast reconstruction surgery following mastectomy.
- Rehabilitation services and Manipulative Treatment - physical therapy, occupational therapy, Manipulative Treatment, and speech therapy.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; psychological testing;

extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

- Surgery - only for the following outpatient surgeries: cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant, and sleep apnea surgeries.
- Temporomandibular joint services and craniomandibular disorder services.
- Therapeutics - only for the following services: intensity modulated radiation therapy and MR-guided focused ultrasound.
- Transplants.

For all other services, when you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis (Medicare pays before we pay Benefits under the Policy), the prior authorization requirements do not apply to you. Since Medicare is the primary payer, we will pay as secondary payer as described in *Section 7: Coordination of Benefits*. You are not required to obtain authorization before receiving Covered Health Services.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
<p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>When a Covered Person was previously covered under a group policy that was replaced by the group Policy, any amount already applied to that annual deductible provision of the prior policy will apply to the Annual Deductible provision under the Policy.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	<p>Network</p> <p>\$2,000 per Covered Person, not to exceed \$4,000 for all Covered Persons in a family.</p> <p>Non-Network</p> <p>\$5,000 per Covered Person, not to exceed \$10,000 for all Covered Persons in a family.</p>
Out-of-Pocket Maximum	
<p>The maximum you pay per year for the Annual Deductible, Copayments or Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> Any charges for non-Covered Health Services. The amount Benefits are reduced if you do not obtain prior authorization as required. Charges that exceed Eligible Expenses. 	<p>Network</p> <p>\$6,000 per Covered Person, not to exceed \$12,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Maximum includes the Annual Deductible.</p> <p>Non-Network</p> <p>\$10,000 per Covered Person, not to exceed \$20,000 for all Covered Persons in a family.</p> <p>The Out-of-Pocket Maximum includes the Annual Deductible.</p>

Payment Term And Description	Amounts
<ul style="list-style-type: none"> Copayments or Coinsurance for any Covered Health Service identified in the <i>Schedule of Benefits</i> table that does not apply to the Out-of-Pocket Maximum. 	
Copayment	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> The applicable Copayment. The Eligible Expense. <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
Coinsurance	
<p>Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. Acupuncture Services			
Limited to 20 treatments per year.	Network 100% after you pay a Copayment of \$30 per visit	Yes	No
	Non-Network 50%	Yes	Yes
2. Ambulance Services			
<p align="center">Prior Authorization Requirement</p> <p>In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary. Prior Authorization is not required when benefits include transportation, including air transport, when necessary to protect the life of the infant or mother, for medically high-risk pregnant women with an impending delivery of a potentially viable infant to the nearest available Tertiary Care Facility for newly-born infants.</p>			
Emergency Ambulance	Network Ground Ambulance: 70%	Yes	Yes
	Air Ambulance: 70%	Yes	Yes
	Non-Network Same as Network	Same as Network	Same as Network

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Non-Emergency Ambulance Ground or air ambulance, as we determine appropriate.	Network Ground Ambulance: 70%	 Yes	 Yes
	Air Ambulance: 70%	 Yes	 Yes
	Non-Network Same as Network	 Same as Network	 Same as Network
3. Clinical Trials			
<p style="text-align: center;">Prior Authorization Recommended</p> <p>You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises so that we can determine whether the services meet the definition of a Covered Service. If the services do not meet the definition of a Covered Health Service or the clinical trial does not meet the criteria to be a qualifying clinical trial, you fail to obtain prior authorization as required, Benefits may be denied if determined not Medically Necessary.</p>			
Depending upon the Covered Health Service, Benefit limits are the same as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> .	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		
Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)			
4. Congenital Heart Disease Surgeries			
<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a congenital heart disease (CHD) surgery arises. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
Network and Non-Network Benefits under this section include only the inpatient facility charges for the congenital heart disease (CHD) surgery. Depending upon where the Covered Health Service is provided, Benefits for diagnostic services, cardiac catheterization and non-surgical management of CHD will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .	<p>Network</p> <p>70%</p>	Yes	Yes
	<p>Non-Network</p> <p>50%</p>	Yes	Yes
5. Dental Services - Accident Only			
<p align="center">Prior Authorization Requirement</p> <p>For Network and Non-Network Benefits you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. (You do not have to obtain prior authorization before the initial Emergency treatment.) If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
	<p>Network</p> <p>70%</p>	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network Same as Network	Same as Network	Same as Network
6. Diabetes Services			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization before obtaining any diabetes equipment for the management and treatment of diabetes that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for inpatient or outpatient services.		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for inpatient or outpatient services.		
Diabetes Self-Management Items Benefits for diabetes equipment that meets the definition of Durable Medical Equipment are not subject to the limit stated under <i>Durable Medical Equipment</i> .	Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i> .		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i> .		
7. Durable Medical Equipment			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.			
Benefits are limited to a single purchase of a type of DME (including repair/replacement) every three years. This limit does not apply to wound vacuums. To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	Network 70%	Yes	Yes
	Non-Network 50%	Yes	Yes
8. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate,	Network 100% after you pay a Copayment of \$350 per visit . If you are admitted as an inpatient to a Network	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Network Benefits will not be provided. Non-Network Benefits may be available if the continued stay is determined to be a Covered Health Service.	Hospital directly from the Emergency room, you will not have to pay this Copayment. The Benefits for an Inpatient Stay in a Network Hospital will apply instead.		
	Non-Network Same as Network	Same as Network	Same as Network
9. Hearing Aids			
For covered Enrolled Dependent children under the age of 18 or under the age of 21 if the child is still attending high school, covered with no dollar limits: All other enrollees, Limited to \$2,500 in Eligible Expenses per year. Benefits are further limited to a single purchase (including repair/replacement) per hearing impaired ear every three years.	Network 70%	Yes	Yes
	Non-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
10. Home Health Care			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before receiving services or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
Limited to 100 visits per year. One visit equals up to four hours of skilled care services.	Network 70%	Yes	Yes
	Non-Network 50%	Yes	Yes
11. Hospice Care			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p> <p>In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.</p>			
	Network 70%	Yes	Yes
	Non-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
12. Hospital - Inpatient Stay			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions). If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p>			
	Network 70%	Yes	Yes
	Non-Network 50%	Yes	Yes
13. Lab, X-Ray and Diagnostics - Outpatient			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits for sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
Lab Testing - Outpatient:	Network 70%	Yes	Yes
	Non-Network 50%	Yes	Yes
X-Ray and Other Diagnostic Testing - Outpatient:	Network 70%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	<i>Non-Network</i> 50%	Yes	Yes
14. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
	<i>Network</i> 100% after you pay a Copayment of \$400 per service	Yes	No
	<i>Non-Network</i> 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
15. Mental Health Services			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
	<p>Network</p> <p><i>Inpatient</i></p> <p>70%</p>	Yes	Yes
	<p><i>Outpatient</i></p> <p>100% after you pay a Copayment of \$60 per visit .</p>	Yes	No
	<p>Non-Network</p> <p><i>Inpatient</i></p> <p>50%</p>	Yes	Yes
	<p><i>Outpatient</i></p> <p>50%</p>	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
16. Neurobiological Disorders - Autism Spectrum Disorder Services			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission for Neurobiological Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
	<p style="text-align: center;">Network</p> <p style="text-align: center;"><i>Inpatient</i></p> <p style="text-align: center;">70%</p>	Yes	Yes
	<p style="text-align: center;"><i>Outpatient</i></p> <p style="text-align: center;">100% after you pay a Copayment of \$60 per visit .</p>	Yes	No
	<p style="text-align: center;">Non-Network</p> <p style="text-align: center;"><i>Inpatient</i></p> <p style="text-align: center;">50%</p>	Yes	Yes
	<p style="text-align: center;"><i>Outpatient</i></p> <p style="text-align: center;">50%</p>	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
17. Obesity Surgery			
<p>Prior Authorization Requirement</p> <p>You must obtain prior authorization six months prior to surgery or as soon as the possibility of obesity surgery arises. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p> <p>It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs that are designed to achieve the best outcomes for you.</p>			
Benefits are limited to one procedure per lifetime. Benefits for obesity surgery are subject to payment of the Annual Deductible and Coinsurance applies to the Out-of-Pocket Maximum.	<p>Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.</p>		
Non-Network Benefits include services provided at a Network facility that is not a Designated Facility and services provided at a non-Network facility.	<p>Non-Network</p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.</p>		
18. Ostomy Supplies			
Limited to \$2,500 per year.	<p>Network</p> 70%	Yes	Yes
	<p>Non-Network</p> 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
19. Pharmaceutical Products - Outpatient			
	Network 70%	Yes	Yes
	Non-Network 50%	Yes	Yes
20. Physician Fees for Surgical and Medical Services			
	Network 70%	Yes	Yes
Covered Health Services provided by a non-Network consulting Physician, assistant surgeon or a surgical assistant in a Network facility will be paid as Network Benefits. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.	Non-Network 50%	Yes	Yes
21. Physician’s Office Services - Sickness and Injury			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before Genetic Testing - BRCA is performed. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed in a Physician’s office:	Network 100% after you pay a Copayment of	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<ul style="list-style-type: none">• Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient</i>.• Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>.• Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>.• Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>.• Outpatient surgery procedures described under <i>Surgery - Outpatient</i>.• Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>.	\$30 per visit for a Primary Physician office visit or \$60 per visit for a Specialist Physician office visit		
	Non-Network 50%	Yes	Yes
22. Pregnancy - Maternity Services			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be more than 48 hours for the mother and newborn child following a normal vaginal delivery, or more than 96 hours for the mother and newborn child following a cesarean section delivery. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p> <p>It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.</p>			
	<p>Network</p> <p>Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services</p>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay. For Covered Health Services provided in the Physician's Office, a Copayment will apply only to the initial office visit.		
	Non-Network Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.		
23. Preventive Care Services			
Physician office services	Network 100%	No	No
	Non-Network 50%	Yes	Yes
Lab, X-ray or other preventive tests	Network 100%	No	No
	Non-Network 50%	Yes	Yes
Breast pumps	Network 100%	No	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 50%	Yes	Yes
24. Prosthetic Devices			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed \$1,000 in cost per device. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
Benefits are limited to a single purchase of each type of prosthetic device every three years.	Network 70%	Yes	Yes
Once this limit is reached, Benefits continue to be available for items required by the <i>Women’s Health and Cancer Rights Act of 1998</i> .	Non-Network 50%	Yes	Yes
25. Reconstructive Procedures			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions (including Emergency admissions).</p>			
Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the Women’s Health and Cancer Rights Act of 1998, including breast prostheses and treatment of	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
complications, are provided in the same manner and at the same level as those for any other Covered Health Service.	Schedule of Benefits for either inpatient or outpatient services.		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits for either inpatient or outpatient services.		
26. Rehabilitation Services - Outpatient Therapy and Manipulative Treatment			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization five business days before receiving physical therapy, occupational therapy, Manipulative Treatment, and speech therapy or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.			
Limited per year as follows: <ul style="list-style-type: none">• 20 visits of physical therapy.• 20 visits of occupational therapy.• 20 Manipulative Treatments.• 20 visits of speech therapy.• 20 visits of pulmonary rehabilitation therapy.• 36 visits of cardiac rehabilitation therapy.• 30 visits of post-cochlear implant aural therapy.• 20 visits of cognitive rehabilitation therapy.	Network 100% after you pay a Copayment of \$30 per visit	Yes	No
	Non-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
27. Scopic Procedures - Outpatient Diagnostic and Therapeutic			
	Network 70%	Yes	Yes
	Non-Network 50%	Yes	Yes
28. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p>			
Limited to 60 days per year.	Network 70%	Yes	Yes
	Non-Network 50%	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
29. Substance Use Disorder Services			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission for Substance Use Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological al testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
	<p>Network</p> <p><i>Inpatient</i></p> <p>70%</p>	Yes	Yes
	<p><i>Outpatient</i></p> <p>100% after you pay a Copayment of \$60 per visit .</p>	Yes	No
	<p>Non-Network</p> <p><i>Inpatient</i></p> <p>50%</p>	Yes	Yes
	<p><i>Outpatient</i></p> <p>50%</p>	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
30. Surgery - Outpatient			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
	Network 70%	Yes	Yes
	Non-Network 50%	Yes	Yes
31. Temporomandibular Joint Services and Craniomandibular Disorder Services			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.</p>			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		
32. Therapeutic Treatments - Outpatient			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p>			
	<p style="text-align: center;">Network</p> <p>70%</p>	Yes	Yes
	<p style="text-align: center;">Non-Network</p> <p>50%</p>	Yes	Yes
33. Transplantation Services			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits may be denied if the service is determined not Medically Necessary.</p> <p>For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits may be denied if the service is determined not Medically Necessary.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).</p>			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		
34. Urgent Care Center Services			
In addition to the Copayment stated in this section, the Copayments/Coinsurance and any deductible for the following services apply when the Covered Health Service is performed at an Urgent Care Center: <ul style="list-style-type: none"> • Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient</i>. • Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient</i>. • Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>. • Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>. • Outpatient surgery procedures described under <i>Surgery - Outpatient</i>. • Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>. 	Network 100% after you pay a Copayment of \$75 per visit	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Non-Network 50%	Yes	Yes
Additional Benefits Required By New Mexico Law			
35. Dental Services - Hospitalization and General Anesthesia			
Prior Authorization Requirement Depending upon where the Covered Health Service is provided, any applicable notification requirements will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits for either inpatient or outpatient services.		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits for either inpatient or outpatient services.		
36.Early Intervention Services			
Prior Authorization Requirement Depending upon where the Covered Health Service is provided, any applicable notification requirements will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		
37.Genetic Inborn Errors of Metabolism			
Prior Authorization Requirement Depending upon where the Covered Health Service is provided, any applicable notification requirements will be the same as those stated under each Covered Health Service category in this Schedule of Benefits.			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services or as provided under the <i>Outpatient Prescription Drug Rider</i> .		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services or as provided under the <i>Outpatient Prescription Drug Rider</i> .		
38. Osteoporosis Treatment			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		
39. Smoking Cessation Treatment			
Limited to: <ul style="list-style-type: none"> • 90 minutes of one-on-one counseling per year. • Two multi-session group counseling programs per year. Initiation of any course of pharmacotherapy or cessation counseling shall constitute an entire course regardless if the Covered Person discontinues or fails to complete the course.	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		
	Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		

<i>When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.</i>			
Covered Health Service	Benefit (<i>The Amount We Pay, based on Eligible Expenses</i>)	Apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
40. Telemedicine			
	<i>Network</i> Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		
	<i>Non-Network</i> Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> for either inpatient or outpatient services.		

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Certificate*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as otherwise arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by state law.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, at our discretion.
 - If rates have not been negotiated, then one of the following amounts:

- ◆ Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
- ◆ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - o For services other than Pharmaceutical Products, we use a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by *Ingenix, Inc.* If the *Ingenix, Inc.* relative value scale becomes no longer available, a comparable scale will be used. We and *Ingenix, Inc.* are related companies through common ownership by *UnitedHealth Group*.
 - o For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
- ◆ When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under *CMS* published rates or a gap methodology, the Eligible Expense is based on 50% of the provider's billed charge, except that certain Eligible Expenses for Mental Health Services and Substance Use Disorder Services are based on 80% of the billed charge.
- ◆ For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses at our discretion.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Network Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Network Physician to coordinate care through a non-Network provider.

Questions, Complaints and Appeals Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified by replacing *Section 6: Questions, Complaints and Appeals* of the *Certificate of Coverage* with the provision below.

Because this Amendment is part of a legal document (the group Policy), we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* and in this Amendment below.

1. *The provision in the Certificate under Section 6: Questions, Complaints and Appeals is replaced with the following:*

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

If you would rather send your complaint to us in writing, the *Customer Care* representative can provide you with the appropriate address.

If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, he/she can help you prepare and submit a written complaint.

Information about Grievance Procedures

- For Grievants, we shall include a clear and concise description of all grievance procedures, both internal and external, on the enrollment materials, including member handbooks or evidence of coverage issued to Grievants.
- For a person who has been denied coverage, provide him or her with a copy of the grievance procedures.
- Notify Grievants that a representative of the Health Care Insurer and the managed health care bureau of the insurance division are available upon request to assist Grievants with grievance procedures by including such information, and a toll-free number for obtaining such assistance, in the enrollment materials and summary of benefits issued to Grievants.
- Provide a copy of its grievance procedures and all necessary grievance forms at each decision point in the grievance process and immediately upon request, at any time, to a Grievant, provider or other interested person.
- "Provider" means a duly licensed hospital or other licensed facility, physician, or other Health Care Professional authorized to furnish Health Care Services.
- Provide a detailed written explanation of the appropriate grievance procedure and a copy of the grievance form to a Grievant or provider when we make either an adverse determination or adverse administrative decision; the written explanation shall describe how we review and resolve grievances and provide a toll-free telephone number, facsimile number, e-mail address, and mailing address of the our consumer assistance office.

- Provide consumer education brochures and materials developed and approved by the *Superintendent of Insurance* in consultation with us for distribution.
- Provide Culturally and Linguistically Appropriate Manner of Notice to the enrollee.
- Provide continued coverage for an ongoing course of treatment pending the outcome of an internal appeal.
- Not reduce or terminate an ongoing course of treatment without first notifying you sufficiently in advance of the reduction or termination to allow the Grievant to appeal and obtain a determination on review of the proposed reduction or termination.
- Allow individuals in urgent care situations and receiving an ongoing course of treatment to proceed with an expedited external review at the same time as the internal review process.
- We shall inform all providers of the grievance procedures available to Grievants and providers acting on behalf of Grievants, and shall make all necessary forms available to providers, including consumer education brochures and materials developed and approved by the *Superintendent of Insurance*, annually or as directed by the *Superintendent of Insurance* in consultation with us for distribution.
- We shall maintain a grievance register to record all grievances received and handled during the calendar year. The register shall be maintained in a manner that is reasonably clear and accessible to the *Superintendent of Insurance*. We will maintain such records for at least 6 years. We will submit information regarding all grievances involving quality of care issues to the Health Care Insurer's continuous quality improvement committee and to the *Superintendent* and will document the qualifications and background of the continuous quality improvement committee members. For each grievance received, the grievance register will:
 - assign a grievance number,
 - indicate whether the grievance is an adverse determination or administrative grievance, or a combination of both;
 - state the date, and for an expedited review, the time the grievance was received;
 - state the name and address of the Grievant, if different from the Grievant;
 - identify by name and member number the Grievant making the grievances or for whom the grievance was made;
 - indicate whether the Grievant's coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act, the medicaid program, or a commercial Health Care Insurer;
 - identify the health insurance policy number and the group if the policy is a group policy;
 - identify the individual employee of the Health Care Insurer to whom the grievance was made;
 - describe the grievance;
 - for adverse determination grievances, indicate whether the grievance received expedited or standard review;
 - indicate as to what level of grievance was resolved and what the actual outcome was; and
 - state the date the grievance was resolved and the date the Grievant was notified of the outcome.
- Information about grievance procedures must be provided in accordance with the Americans with Disabilities Act, 42 U.S.C. Sections 12101 et seq., and 13.10.13 NMAC, Managed Health Care, particularly 13.10.13.29 NMAC, Cultural and Linguistic Diversity.

Introduction to Grievance Procedures

There are two different procedures depending on the type of issue involved: An administrative grievance and an adverse determination grievance.

An "administrative grievance" is an oral or written complaint submitted by or on behalf of a Covered Person regarding any aspect of the Enrolling Group benefit plan other than a request for Health Care Services, including but not limited to:

- Administrative practices that affect the availability, delivery, or quality of Health Care Services.

- Claim payment, handling or reimbursement for Health Care Services.
- Termination of coverage.

An "adverse determination" means any Rescission of Coverage (whether or not the rescission has an adverse effect on any particular benefit at the time), a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payments, that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

An "adverse determination grievance" is an oral or written complaint submitted by or on behalf of a Grievant regarding an adverse determination.

A grievance may include a "medical necessity" or "Medically Necessary" complaint which means Health Care Services determined by a provider, in consultation with Health Care Insurer, to be appropriate or necessary, according to any applicable generally accepted principles and practices of good medical care or practice guidelines developed by the federal government, national or professional medical societies, boards and associations, or any applicable clinical protocols or practice guidelines developed by the Health Care Insurer consistent with such federal, national and professional practice guidelines, for the diagnosis or direct care and treatment of a physical, behavioral, or mental health condition, illness, injury or disease.

Upon receipt of the grievance, we will determine what type of grievance it is and follow the applicable process for that grievance as described below.

If a grievance contains clearly divisible administrative and adverse decision issues, then we shall initiate separate complaints for each issue; with an explanation of our actions contained in one acknowledgement letter.

We, along with the *Superintendent of Insurance*, Independent Co-Hearing Officers and all others who have access to identifiable medical records and information of a Covered Person while reviewing a grievance, will treat and maintain such records and information as confidential, except as provided for by federal law and/or New Mexico law. We and the *Superintendent of Insurance* will establish procedures to ensure that such records and information are treated as confidential.

Assistance Available

If you make an oral grievance or request for internal review to us, or express interest in pursuing a written grievance, we shall assist you to complete all the forms required to pursue internal review and shall advise you that the managed health care bureau of the insurance division is available for assistance.

No person shall be subject to retaliatory action by us for any reason related to a grievance.

Computation of Time

Whenever an action must be taken within a certain period of time from receipt of a request or document, the request or document shall be deemed to have been received within 3 working days of the date it was mailed.

Initial Determination

When we receive a request to certify Health Care Services from a provider or Covered Person, we shall determine whether the requested Health Care Service is covered.

Before we deny a request for Health Care Services for lack of coverage, we will determine if the health care service can be covered under any other provision. If it is determined that the Health Care Service cannot be covered under any other provision, we need not address the issue of medical necessity.

If it is determined that the health care service is covered, we then determine if the Health Care Service is Medically Necessary. Before we deny a request for Health Care Services for a lack of Medical Necessity, a physician shall render an opinion as to medical necessity, either after consultation with specialist who are experts in the area that is the subject of review, or after application of Uniform Standards used by us. The physician shall be under the clinical authority of the medical director responsible for Health Care Services provided to Covered Persons.

We will make our initial certification or adverse determination decision based on the medical exigencies of the

case. We will make our decision within 24 hours of the written or verbal receipt of the request for an expedited decision whenever:

- Your life or health or the ability to regain maximum function may be jeopardized.
- The provider reasonably requests an expedited review.
- In the opinion of the physician with knowledge of the Grievant's medical condition, would subject the Grievant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
- The medical exigencies of the case require an expedited review.
- The Grievant's claim involves urgent care.

We will make all other initial utilization management decisions within 5 working days. We may take up to 10 working days if we:

- Demonstrate reasonable cause beyond our control for the delay.
- Demonstrate the delay will not result in an increased medical risk to the Covered Person.
- Provide a written progress report and explanation for the delay to the Covered Person and the provider within the initial 5 working day review period.

We will notify you and the provider by written or electronic communication within 2 working days from the date the health care service was certified, unless earlier notice is required due to the medical exigencies of the case.

We will notify you and the provider of an adverse determination by telephone within 24 hours after making the adverse determination, unless you fail to provide sufficient information to determine whether, or to what extent benefits are covered or payable under the plan or have insurance coverage. If you fail to provide such information, you must be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. Additionally, we will notify you and the provider by written or electronic communication within 1 working day of the telephone notification. The notice shall:

- Clearly and completely explain why the requested health care service is not Medically Necessary when the adverse determination is based on a lack of medical necessity.
- Clearly and completely explain why the requested health care service is not covered by any provision and identify all the provisions that we relied on in making the adverse determination based on a lack of coverage.
- Provide the date of service, the health care provider, the claim amount, the diagnosis code, the treatment code and corresponding meaning of these codes, the denial code and its corresponding meaning.
- Include a description of our standard that was used in denying the claim.
- Provide a summary of the discussion which triggered the final determination.
- Advise you that you may request an internal or external review of our adverse determination and provide you with a description of the procedures and all forms required to be completed.
- Describe the procedures and provide all necessary forms to the Grievant for requesting internal appeals and external reviews.

The Administrative Grievance Process

If you are dissatisfied with an administrative decision, action or inaction, including Termination of Coverage, you are entitled to request an internal review of an administrative grievance, either orally or in writing.

- The first level of internal review will be done by one of our representatives who are authorized to take corrective action and allow you to present any information pertinent to the administrative grievance. We will send you a written acknowledgement that we have received your administrative grievance within 3 working days. The written acknowledgement will include the name, address and direct telephone number of an individual representative of ours who may be contacted regarding the administrative grievance.
- We will mail a written decision to you within 15 working days of receipt of the administrative grievance. If there is a delay in obtaining documents or records necessary for the review of your administrative grievance the time period for our decision may be extended. If we require an extension we will notify you in writing and include the reasons the extension is required and also provide the expected date of resolution. The time period for our decision may also be extended by a mutual written agreement between you and us.

- The written decision will contain:
 - The name, title, and qualifications of the person conducting the initial review.
 - A statement of the reviewer's understanding of the administrative grievance and all pertinent facts.
 - A clear and complete explanation of:
 - ♦ The reasoning for the reviewer's decision.
 - ♦ The Health Benefit Plan provisions relied upon in reaching the decision.
 - ♦ Any documentation or evidence considered by the reviewer in reaching the decision.
 - A statement that the initial decision will be binding unless you submit a request for reconsideration within 20 working days of receipt of the initial decision.
 - A description of the procedures and deadlines for requesting reconsideration of the initial decision, including any necessary forms.
- If you are dissatisfied with the results of the first level of internal review, you can request that the administrative grievance be reconsidered by an internal review committee. This committee will contain one or more employees who have not participated in the initial decision. We may include one or more Covered Persons who were not involved in the initial decision.
- The reconsideration committee will schedule and hold a hearing within 15 working days after receipt for reconsideration. The hearing will be held during regular business hours at a location reasonably accessible to you, and we will offer you the opportunity to communicate with the committee, at our expense, by conference call, video conferencing, or other appropriate technology. We will not unreasonably deny a request for postponement of the hearing made by you.
- We will notify you in writing of the hearing date, time and place at least 10 working days in advance. The notice will advise you of the rights specified below. If we have an attorney represent our interests, the notice will advise you that we will be represented by an attorney and that you may wish to obtain legal representation of your own.
- No fewer than three working days prior to the hearing, we will provide you with all documents and information that the committee will rely on in reviewing the case.
- You have the right to:
 - Attend the reconsideration committee hearing.
 - Present your case to the reconsideration committee.
 - Submit supporting material both before and at the reconsideration committee hearing.
 - Ask questions of any of our representatives.
 - Be assisted or represented by a person of your choice.

Decision of the Reconsideration Committee

We will mail a written decision to you within seven working days after the reconsideration committee hearing. The written decision will include:

- The name, titles, and qualifications of the persons on the reconsideration committee.
- The reconsideration committee's statement of the issues involved in the administrative grievance.
- A clear and complete explanation of the rationale for the reconsideration committee's decision.
- The health benefits plan provision relied upon in reaching the decision.
- References to the evidence or documentation relied on in reaching the decision.
- A statement that the initial decision will be binding unless you submit a request for external review by the *Superintendent* within 20 working days of receipt of the reconsideration decision.
- A description of the procedures and deadlines for requesting external review by the *Superintendent*, including any necessary forms. The notice will contain the toll-free telephone number and address of the *Superintendent's* office.

External Review of Administrative Grievances by the New Mexico Superintendent of Insurance

Every Grievant who is dissatisfied with the results of the internal review of an administrative decision will have the right to request external review by the *Superintendent of Insurance*. The *Superintendent of Insurance* may require you to exhaust the grievance procedures adopted by us, as appropriate, before accepting a grievance for external review.

To initiate an external review, you must file a written request for external review with the *Superintendent of Insurance* within 20 calendar days from the receipt of the written notice of reconsideration decision. If you wish to supply supporting documents or information subsequent to filing the request for external review, the timeframes for external review will be extended up to 90 days from receipt of the complaint form, or until you submit all supporting documentation, whichever comes first.

The request must be submitted using one of the following methods:

- Mailed to the *Superintendent of Insurance* at:
Attn: Managed Health Care Bureau - External Review Request, New Mexico Public Regulation Commission, Post Office Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269
- Emailed to mhcb.grievance@state.nm.us, subject External Review Request.
- Faxed to the *Superintendent of Insurance* Attn: Managed Care Health Bureau - External Review Request, at (505) 827-4734.
- Completed on-line with a NM PRC, Division of Insurance complaint form available at <http://www.nmprc.state.nm.us>.

If required by the medical urgency of the case, a Covered Person or provider may request an expedited review by telephone to the *Managed Health Care Bureau* at (505) 827-3928 or 1-888-673-1732.

You must file the request for external review on forms provided to you by us. You may also file any other supporting documentation or information you wish to submit to the *Superintendent of Insurance* for review.

You will need to provide a copy of the grievance decision from us, a fully executed release form authorizing the *Superintendent of Insurance* to obtain any necessary medical records from us or any other relevant provider, if the grievance involves an experimental or investigational treatment adverse determination, the provider's certification and recommendation and any other supporting documents or information you may want to submit for review.

Upon receipt of the copy of the request for external review, we will provide the documents and information considered in making the administrative grievance decision within 5 working days to you and the *Superintendent of Insurance*. The *Superintendent of Insurance* will immediately send you an acknowledgement that the request has been received and will provide us with a copy of the request for the external review.

The *Superintendent of Insurance* will review the documents and information submitted by you, and by us, and may conduct an investigation or inquiry or consult with you, as appropriate. The *Superintendent of Insurance* will issue a written decision on the administrative grievance within 20 working days from receipt of the completed request or external review.

If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:

- We waive the exhaustion requirement;
- We are considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or
- You simultaneously request an expedited internal appeal and an expedited external review.

The internal claims and appeals process will not be deemed exhausted based on violations by us that are de minimus and do not cause, and are not likely to cause, prejudice or harm to the Grievant, so long as we demonstrate that the violation was for good cause or due to matters beyond the control of us, and that the violation occurred in the context of any ongoing, good faith exchange of information between the plan and us. This exception is not available if the violation is part of a pattern or practice of violations by us.

You may request a written explanation of the violation from us and we must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the

internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that we met the standards for exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), we shall provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

The Adverse Determination Grievance Process

How to Request an Internal Review of an Adverse Determination

Every Grievant who is dissatisfied with an adverse determination has the right to request an internal review of the adverse determination. If you informally contact *Customer Care* first and later wish to submit a formal grievance, you may contact *Customer Care* and a representative will assist you in preparing a formal grievance.

Your request for a grievance should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

If you are requesting an expedited review of an adverse determination please see *Expedited Review of an Adverse Determination* below.

First and Second Internal Review of an Adverse Determination Process

We will send you a written acknowledgement that we have received your request for review of the adverse determination within 1 working day. We will date and time stamp the request when we receive it. The written acknowledgement will include the name, address and direct telephone number of an individual representative of ours who may be contacted regarding the request.

To ensure that you receive a full and fair internal review, we, in addition to allowing you to review the claim file and to present evidence and testimony as part of the internal claims and appeals process, provide you, free of charge, with any new or additional evidence, and new or additional rationale, considered relied upon, or generated by us, as soon as possible and sufficiently in advance of the date of the notice of final internal adverse benefit determination is made.

We will ensure that all internal claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions in such a way that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

When we receive your request for review of the adverse determination we will conduct either a standard or expedited review, as appropriate.

If your grievance is related to clinical matters, we will complete our review of the adverse determination within the timeframes required by the medical exigencies of the case. We may consult with, or seek the participation of, medical experts as part of the grievance resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits.

If the adverse determination was based on a lack of medical necessity, we shall render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of the review, or after application of Uniform Standards used by us.

The internal review of an adverse determination (first level) will be decided by us. We will determine if the health care service can be covered under any provision. If we reverse the initial adverse determination and certify the health care service, we will notify you and your provider. If we uphold the initial adverse determination to deny the requested health care service, you and your provider will be notified of our decision by telephone or in writing. If

we are unable to contact you by telephone within 72 hours of making the decision to uphold the determination, we will notify you by mail of our decision and will include in the notification a self-addressed stamped response form asking you whether you wish to pursue the grievance further. If you do not return the response form within 10 working days, we will contact you by telephone to confirm whether you wish to pursue the grievance further. If you respond affirmatively to the telephone inquiry or by response form, we will select a medical panel to further review the adverse determination. For expedited reviews, we will select a medical panel to further review the adverse determination. If you do not make an immediate decision to pursue the grievance or you request additional time to supply supporting documentation or information, or postponement, the timeframes described above shall be extended to include the additional time you require. If you respond that you do not wish to pursue the grievance, we will mail you a written notification of our decision and a confirmation of your decision to not pursue the matter further within 3 working days from the date of our decision or within 3 working days from the date we receive your response.

If you are not satisfied with the first level determination, you have the right to request an internal panel review of an adverse determination (second level). Your second level request must be submitted to us within 20 days from the receipt of the first level determination, however, we will not unreasonably deny a request for postponement of the internal panel review that you make. The timeframes for the internal panel review shall be extended during the period of any postponement agreed upon. You will be notified of the date, time and place of the internal review panel. The internal review panel will contain one or more of our representatives and one or more Health Care Professionals who were not previously involved in the adverse determination of your grievance. At least one of the Health Care Professionals selected shall practice in a specialty that would typically manage the case that is the subject of the grievance, or be mutually agreed upon by you and us. Internal panel members must be physically present or present via telephone or video conferencing to hear the grievance or they shall not participate in the panel. The internal panel will determine if the health care service can be covered under any provision or the internal panel will render an opinion as to medical necessity, either after consultation with specialists who are experts in the area that is the subject of the review, or after application of Uniform Standards used by us. The internal panel will notify you if we are represented by an attorney and advise you that you may wish to obtain legal representation as well. You will be notified of the decision by telephone within 24 hours of the panel's decision and in writing or by electronic means within 1 working day of the telephone notice. The written notice shall contain:

- The names, titles and qualifying credentials of the persons on the internal review panel.
- A statement of the internal review panel's understanding of the nature of the grievance and all pertinent facts.
- A description of the evidence relied on by the internal review panel in reaching its decision.
- A clear and complete explanation of the rationale for the internal review panel's decision.
- An explanation as to why each provision did or did not support the internal review panel's decision regarding coverage.
- Citations to the Uniform Standards relevant to your medical condition and explain whether each supported or did not support the internal review panel's decision regarding medical necessity of the requested health care service.
- Notice of your right to request an external review by the *Superintendent of Insurance*, including the address and telephone number of the Managed Health Care Bureau of the Insurance Division, a description of all procedures and time deadlines necessary to pursue an external review and copies of any forms required to initiate the external review.

With regard to the second level request, you have the right to:

- Attend and participate in the internal panel review hearing.
- Present your case to the review committee.
- Submit supporting material both before and at the review hearing.
- Ask questions of any of our representatives.
- Ask questions of any health professionals on the internal panel.
- Be assisted or represented by a person of your choice, including legal representation.
- Hire a specialist to participate in the internal panel review at his or her own expense, but such specialist may not participate in making the decision.

Within three working days prior to the internal panel review, we will provide you copies of:

- The covered person's pertinent medical records.
- The treating provider's recommendation.
- The Covered Person's Health Benefit Plan.
- Our notice of adverse determination.
- Uniform Standards relevant to the Grievant's medical condition that is used by the internal panel in reviewing the adverse determination;
- Questions sent to or reports received from any medical consultants retained by us.
- All other evidence or documentation relevant to reviewing the adverse determination.

For grievances relating to pre-service requests for Benefits, both the internal review and internal panel review (as applicable) will be completed within 20 working days from receipt of a request a grievance that contains all of the information you wish the committee to review. For grievances relating to post-service determination, both the internal review and internal panel review (as applicable) will be completed within 40 days from receipt of a grievance for Benefits or claim that contains all the information you wish the committee to review.

We may extend the review for a maximum of 10 working days for pre-service requests, and a maximum of 20 working days for post-service requests if we:

- Demonstrate reasonable cause beyond our control for the delay.
- Demonstrate the delay will not result in an increased medical risk to the Covered Person.
- Provide a written progress report and explanation for the delay to the Covered Person and the provider within the original 30 day time frame for pre-service or 60 day time frame for post-service requests.
- If the grievance contains clearly divisible administrative and adverse decision issues, we shall separate the requests for each decision.
- If we fail to meet the deadlines described above the requested health service shall be deemed approved unless you, after being fully informed of your rights, agreed in writing to extend the deadline.

Expedited Review of an Adverse Determination

Your adverse determination grievance may require immediate action if a delay in treatment could jeopardize your life or health, or the ability to regain maximum function, the provider reasonably requests an expedited decision, the medical exigencies of the case require an expedited decision or, in the opinion of the physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately without the care or treatment that is the subject of the claim. In these urgent situations:

- The request does not need to be submitted in writing. You or your Physician should call us as soon as reasonably possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.
- If we need more information from your Physician to make a decision, we will notify you of the decision by the end of the next business day following receipt of the required information.

During an expedited review we will communicate with you in the most expeditious manner available. If the expedited review is conducted during an Inpatient Hospital Stay or course of treatment, Benefits shall be continued without cost (except for applicable Copayments, Coinsurance or deductibles) until we make a final decision and notify you.

We shall not conduct an expedited review of an adverse determination made after Health Care Services have been provided to you.

External Review of Adverse Determination Grievances by the New Mexico Superintendent of Insurance

Every Grievant who is dissatisfied with the results of the medical panel review of an adverse determination grievance may request external review by the *Superintendent of Insurance* at no cost to you. There shall be no minimum dollar amount of a claim before you may exercise the right to external review.

The *Superintendent of Insurance* may require you to exhaust the grievance procedures adopted by us, as appropriate, before accepting a grievance for external review.

The *Superintendent of Insurance* may require you to exhaust any grievance procedures adopted by us or the entity that purchases health care benefits pursuant to the New Mexico Health Care Purchasing Act, as appropriate, before accepting a grievance for external review.

If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary and the internal appeals process will be deemed exhausted if:

- We waive the exhaustion requirement;
- We are considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process; or
- You simultaneously request an expedited internal appeal and an expedited external review.

The internal claims and appeals process will not be deemed exhausted based on violations by us that are de minimus and do not cause, and are not likely to cause, prejudice or harm to the Grievant, so long as we demonstrate that the violation was for good cause or due to matters beyond the control of us, and that the violation occurred in the context of any ongoing, good faith exchange of information between the plan and us. This exception is not available if the violation is part of a pattern or practice of violations by us.

You may request a written explanation of the violation from us and we must provide such explanation within ten days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an external reviewer or a court rejects your request for immediate review on the basis that we met the standards for exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), we shall provide you with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

To initiate an external review, you must file a written request for external review with the *Superintendent of Insurance* within 120 working days from the receipt of the written notice of internal review decision from us unless extended by the *Superintendent* for good cause shown.

The request must be submitted using one of the following methods:

- Mailed to the *Superintendent of Insurance* at:
Attn: Managed Health Care Bureau - External Review Request, New Mexico Public Regulation Commission, Post Office Box 1269, 1120 Paseo de Peralta, Santa Fe, New Mexico 87504-1269
- Emailed to mhcb.grievance@state.nm.us, subject External Review Request.
- Faxed to the *Superintendent of Insurance* Attn: Managed Care Health Bureau - External Review Request, at (505) 827-4734.
- Completed on-line with a NM PRC, Division of Insurance complaint form available at <http://www/nmprc.state.nm.us>.

If required by the medical urgency of the case, a Covered Person or provider may request an expedited review by telephone to the *Managed Health Care Bureau* at (505) 827-3928 or 1-877-673-1732.

You will need to provide a copy of the grievance decision from us, a fully executed release form authorizing the *Superintendent of Insurance* to obtain any necessary medical records from us or any other relevant provider, if the grievance involves an experimental or investigational treatment adverse determination, the provider's certification and recommendation and any other supporting documents or information you may want to submit for review.

Upon receipt of a request for external review the *Superintendent of Insurance* shall immediately send:

- An acknowledgment of receipt of the request for external review to you.

- A copy of the request for external review to us.

Upon receipt of the copy of the request for external review we will provide the following within 5 working days to you and the *Superintendent of Insurance*:

- A Summary of Benefits.
- The complete health benefits plan, which may be in the form of a member handbook/certificate of coverage.
- All pertinent medical records, internal review decisions and rationales, consulting physician reports, and documents and information submitted by you and/or by us.
- Uniform Standards relevant to your medical condition that were used by the internal review panel in reviewing the adverse determination.
- Any other documents, records and information relevant to the adverse determination and the internal review decision or intended to be relied on at the external review hearing.

If we fail to comply with these requirements, the *Superintendent of Insurance* may reverse the adverse determination.

The *Superintendent of Insurance* may waive these requirements if necessitated by the medical exigencies of the case.

- The *Superintendent of Insurance* will conduct either a standard or expedited external review of the adverse determination as required by the medical exigencies of the case.
 - For an expedited review, the *Superintendent of Insurance* shall complete an external review no later than 72 hours from receipt of the external review request when a delay in treatment could jeopardize your life or health, or the ability to regain maximum function. If the *Superintendent of Insurance's* initial decision is made orally, written notice of the decision must be provided within 48 hours of the oral notification.
 - For a standard review, the *Superintendent of Insurance* shall conduct the initial review within 10 working days from receipt of the request for an external review and all required information for you and us.

If a hearing is held, the *Superintendent of Insurance* shall complete the external review within 45 working days from receipt of the complete request for external review. The *Superintendent of Insurance* may extend the external review period for up to an additional 10 working days when the *Superintendent of Insurance* has been unable to schedule the hearing within the required timeframe and the delay will not result in an increased medical risk to you.

If you wish to supply supporting documentation or information subsequent to the filing of the request for an external review, the timeframes noted above shall be extended up to 90 days from the receipt of the complaint form, or until you submit all supporting documents, whichever occurs first.

Upon receipt of a request for external review, Insurance Division staff shall review the request to determine:

- If you have provided all of the required documents.
- That you are or were a Covered Person of ours at the time the health care service was requested or provided.
- That you have exhausted our internal review procedures and any applicable grievance review procedure of an entity that purchases or is authorized to purchase health care benefits pursuant to the *New Mexico Health Care Purchasing Act*.
- The health care service that is the subject of the grievance reasonably appears to be a covered benefit under your plan.
- If the external review request is for an experimental or investigational treatment adverse determination with regards to coverage, *Insurance Division* staff shall also consider whether the recommended or requested health care service:
- Reasonably appears to be a covered benefit under your plan except for our determination that the health care service is experimental or investigational for a particular medical condition.
- Is not explicitly listed as an excluded benefit.

If the external review request is for an experimental or investigational treatment adverse determination with regards to medical necessity, *Insurance Division* staff shall also consider if your provider has certified that:

- Standard Health Care Services have not been effective in improving your condition.
- Standard Health Care Services are not medically appropriate for you.
- There is no standard health care service covered by us that is as beneficial or more beneficial than the health care service:
 - Recommended by your treating provider that the treating provider certifies in writing is likely to be more beneficial to the covered person, in the treating provider's opinion, than standard Health Care Services.
 - Requested by you which your treating provider, who is a licensed, board certified or board eligible physician qualified to practice in the area of medicine appropriate to treat your condition, has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service requested by you is likely to be more beneficial to you than available standard Health Care Services.

If the Insurance Division staff determines that the request is incomplete, they shall immediately notice you and require you to submit the required information within a specified period of time.

If the Insurance Division staff determines that the request does not meet the required criteria, they shall inform the *Superintendent of Insurance*. The *Superintendent of Insurance* shall notify you and us that the request does not meet the criteria for an external review and is therefore denied, and that you have the right to request a hearing, following the hearing procedures, within 33 days from the date the notice was mailed.

If the Insurance Division staff determines that the request meets the criteria for an external review, they shall inform the *Superintendent of Insurance*. The *Superintendent of Insurance* shall notify you and us that the request meets the criteria for an external review and that an informal hearing has been set to determine whether, as a result of the our adverse determination, you were deprived of Medically Necessary covered services. Prior to the hearing, Insurance Division staff shall attempt to informally resolve the grievance. The notice of hearing shall be mailed no later than 8 working days prior to the hearing date. The notice shall state the date, time and place of the hearing and the matters to be considered and also shall advise you and us of the rights afforded to us by law. The *Superintendent of Insurance* shall not unreasonably deny a request for postponement of the hearing made by you or us.

Hearing Procedures

If a hearing is held, the *Superintendent of Insurance* may designate a Hearing Officer who shall be an attorney licensed in New Mexico. The hearing may be conducted by telephone conference call, video conferencing or other appropriate technology at the Insurance Division expense.

The *Superintendent of Insurance* may designate 2 independent Co-Hearing Officers who shall be licensed Health Care Professionals. If the *Superintendent of Insurance* designates 2 independent co-Hearing Officers, at least one of them shall practice a specialty that would typically manage the case that is the subject of the grievance.

The *Superintendent of Insurance* or Hearing Officer shall regulate the hearing and perform all acts and take all measures necessary or proper for the efficient conduct of the hearing. The *Superintendent of Insurance* or Hearing Officer may:

- Require the production of additional records, documents and writings relevant to the subject of the grievance.
- Exclude any irrelevant, immaterial or unduly repetitious evidence.
- Proceed with the hearing or adjourn the proceedings to a future date if you or we fail to appear. The *Superintendent of Insurance* or Hearing Officer will provide notice of the adjournment to the absent party.

Insurance Division staff may attend the hearing, ask questions and otherwise solicit evidence from the parties, but shall not be present during any deliberations.

The *Superintendent of Insurance* or Hearing Officer may call and examine you, us and any other witnesses. All testimony given at the hearing shall be taken under oath.

The hearing shall be stenographically recorded at the Insurance Division expense.

- Both you and we have the right to:

- Attend the hearing. We shall designate a person or persons to attend on our behalf and you may designate a person or persons to attend on your behalf if you choose to not attend personally.
- Be assisted or represented by an attorney or other person.
- Call, examine and cross-examine witnesses.
- Submit to the Independent Co-Hearing Officer, prior to the scheduled hearing, in writing, additional information that the Independent Co-Hearing Officer must consider when conducting the internal review hearing and require that the information be submitted to us and the Managed Health Care Bureau staff.

Both you and we shall stipulate on the record that the Hearing Officers shall be released from civil liability for all communications, findings, opinions and conclusions made in the course and scope of the external review.

At the close of the hearing, the Hearing Officers shall review and consider the entire record and prepare findings of fact, conclusions of law and a recommended decision. Any Hearing Officer may submit a supplementary or dissenting option to the recommended decision.

Within the above time frame, the *Superintendent of Insurance* shall issue an appropriate order. If the order requires action on our part, the order shall specify the timeframe for us to comply with the order. The order shall be binding on you and us and shall state that you and we have the right to judicial review and that state and federal law may provide other remedies. Neither you nor we may file a subsequent request for an external review for the same adverse determination.

Independent Co-Hearing Officers

The *Superintendent of Insurance* shall provide for maintenance of a list of licensed professionals qualified to serve as Independent Co-Hearing Officers. The *Superintendent of Insurance* shall select appropriate professional societies, organizations, or associations to identify licensed health care and other professional who are willing to service as Independent Co-Hearing Officers in external reviews who maintain independence and impartiality of the process.

Prior to accepting designation as an independent Co-Hearing Officer, each potential independent Co-Hearing Officer shall provide to the *Superintendent of Insurance* a list identifying all Health Care Insurers and providers with whom they maintain any health care related or other professional business arrangements and a brief explanation of the nature of each arrangement. Each independent Co-Hearing Officer shall disclose to the *Superintendent of Insurance* a list identifying all Health Care Insurers and providers with whom they maintain any health care related or other professional business arrangements and a brief explanation of the nature of each arrangement. Each independent Co-Hearing Officer shall disclose to the *Superintendent of Insurance* any other potential conflict of interest that may arise in hearing a particular case, including any personal or professional relationship to you or to us or to providers involved in a particular external review.

The *Superintendent of Insurance* shall consult with appropriate professional societies, organizations, or associations in New Mexico to determine reasonable compensation for appointed independent Co-Hearing Officers for external grievance reviews and shall annually publish a schedule of independent co-hearing compensation in a bulletin.

Upon completion of an external review, that Hearing Officer and Co-Hearing Officers shall each complete a statement of Independent Co-Hearing Officer compensation form prescribed by the *Superintendent of Insurance*, detailing the amount of time spent participating in the external review and submit it to the *Superintendent of Insurance* for approval. The *Superintendent of Insurance* shall send the approved statement of independent co-hearing compensation to us. Within 30 days of the receipt of the statement, we shall remit the approved compensation directly to the Independent Co-Hearing Officer. If the parties provide written notice of a settlement, up to 3 working days prior to the date of the hearing, compensation will not be made to the Hearing Officers or Independent Co-Hearing Officers.

The Hearing Officer and Independent Co-Hearing Officer must maintain written records for a period of at least three years and make them available upon request to the state.

2. The following definitions are added to the Certificate under Section 9: Defined Terms:

Certification - a decision by a Health Care Insurer that a health care service requested by a provider or Grievant has been reviewed and, based upon the information available, meets the Health Care Insurer's requirements for coverage and medical necessity, and the requested health care service is therefore approved.

Culturally and Linguistically Appropriate Manner of Notice - a notice that meets the following requirements:

The Health Care Insurer must provide oral language services (such as a telephone customer assistance hotline) that includes answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;

The Health Care Insurer must provide, upon request, a notice in any applicable non-English language.

The Health Care Insurer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Health Care Insurer.

For the purposes of this definition, with respect to an address in any New Mexico county to which a notice is sent, a non-english language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined by the department of health and human services (HHS); the counties that meet this ten percent standard, as determined by HHS, are found at <http://cciio.cms.gov/resources/factsheets/clas-data.html> and any necessary changes to this list are posted by HHS annually.

Grievant - means any of the following:

- A policyholder, subscriber, enrollee, or other individual, or that person's authorized representative or provider, acting on behalf of that person with that person's consent, entitled to receive health care benefits provided by the health care plan.
- An individual, or that person's authorized representative, who may be entitled to receive health care benefits provided by the health care plan.
- Medicaid recipients enrolled in a Health Care Insurer's Medicaid plan.
- Individuals whose health insurance coverage is provided by an entity that purchases or is authorized to purchase health care benefits pursuant to the New Mexico Health Care Purchasing Act.

Health Benefit Plan - a health plan or a policy, contract, certificate or agreement offered or issued by the Health Care Insurer or plan administrator to provide, deliver, arrange for, pay for, or reimburse the costs of Health Care Services; this includes traditional fee-for-service Health Benefit Plan.

Health Care Insurer - means a person that has a valid certificate of authority in good standing issued pursuant to the insurance code to act as an insurer, health maintenance organization, nonprofit health care plan, fraternal benefit society, vision plan or pre-paid dental plan.

Health Care Professional - a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide Health Care Services consistent with state law.

Health Care Services - services, supplies, and procedures for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease, and includes, to the extent offered by the Health Benefit Plan, physical and mental health services, and services for developmental disability or developmental delay.

Hearing Officer, Independent Co-Hearing Officer or ICO - a health care or other professional licensed to practice medicine or another profession who is willing to assist the Superintendent of Insurance as a Hearing Officer in understanding and analyzing medical necessity and coverage issues that arise in external review hearings.

Rescission of Coverage - means a cancellation or discontinuance of coverage that has retroactive effect; a cancellation or discontinuance of coverage is not a rescission if:

- The cancellation or discontinuance of coverage has only a prospective effect; or
- The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Summary of Benefits - means the written materials to be given to the Grievant by the Health Care Insurer or group contract holder.

Termination of Coverage - means the cancellation or non-renewal of coverage provided by a Health Care Insurer to a Grievant but does not include a voluntary termination by a Grievant or termination of a health benefit.

Traditional Fee-for-Service Indemnity Benefit - means a fee-for-service indemnity benefit, not associated with any financial incentives that encourage Grievants to utilize preferred providers, to follow pre-authorization rules, to utilize prescription drug formularies or other cost-saving procedures to obtain prescription drugs, or to other wise

comply with a plan's incentive program to lower cost and improve quality, regardless of whether the benefit is based on an indemnity form or reimbursement for services.

Uniform Standards - means all generally accepted practice guidelines, evidence-based practice guidelines or practice guidelines developed by the federal government or national and professional medical societies, boards and associations, and any applicable clinical review criteria, policies, practice guidelines, or protocols developed by the Health Care Insurer consistent with the federal, national, and professional practice guidelines that are used by a Health Care Insurer in determining whether to certify or deny a requested health care service.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to read "John H. ...", is positioned above the title "President".

President

Clinical Trials Amendment

UnitedHealthcare Insurance Company

As described in this Amendment, the Policy is modified as stated below. This Amendment is applicable to Policies issued in the state of New Mexico.

Because this Amendment reflects changes in requirements of Federal law, to the extent it may conflict with any Amendment issued to you previously, the provisions of this Amendment will govern.

Any provision of this Amendment which is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which the Amendment is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

1. Clinical Trials

Benefits for routine patient care costs incurred by a Covered Person when participating in a qualifying clinical trial are required under the *Patient Protection and Affordable Care Act (PPACA)*. The Benefit for *Clinical Trials* and the definition of Experimental or Investigational Service(s) in the *Certificate* are replaced as described below:

Section 1: Covered Health Services

Clinical Trials in Section 1: Covered Health Services is replaced with the following:

3. Clinical Trials

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.
- For clinical trials for cancer only, a drug provided during the clinical trial if the drug has been approved by the *U.S. Food and Drug Administration (FDA)*, even if the drug has not been approved by the *FDA* for the treatment of the particular condition, as long as the drug is not paid for by the manufacturer, distributor or provider of the drug.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service or item. The only exceptions to this are:
 - Certain *Category B* devices. *Category B devices* (Non-Experimental, but still Investigational) means a device type in which the underlying questions of safety and effectiveness of that device type have been resolved, or it is known that the device type can be safe and effective because, for example, other manufacturers have obtained *U.S. Food and Drug Administration (FDA)* approval for the device type. These devices are under investigation to establish substantial equivalence to a predicate device, that is, to establish substantial equivalence to a previously/currently legally marketed device.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
 - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

For clinical trials for cancer only:

- *U.S. Food and Drug Administration (FDA)* when related to an investigational new drug application.
- A qualified research entity that meets the criteria established by the *National Institutes of Health (NIH)* for grant eligibility.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Policy.

Section 9: Defined Terms

The definition of Experimental or Investigational Service(s) in Section 9: Defined Terms is replaced with the following:

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, in our discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

UnitedHealthcare Insurance Company



President

Routine Vision Examination Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for routine vision examinations, as described below, for Covered Persons over the age of 19.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 4: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

UnitedHealthcare Insurance Company

A handwritten signature in black ink, appearing to be "J. Kelly", written over a horizontal line.

President

Section 1: Benefits for Routine Vision Examinations

Benefits are available for Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When you obtain Vision Care Services from a non-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim* and in this Rider under *Section 3: Claims for Routine Vision Examinations*. Reimbursement will be limited to the amounts stated below.

When obtaining these Vision Care Services from a Spectera Eyecare Networks Vision Care Provider, you will be required to pay any Copayments at the time of service.

Network Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Non-Network Benefits:

Benefits for Vision Care Services from non-Network providers are determined as a percentage of the provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services under this Rider applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*. Any amount you pay in Copayments for Vision Care Services under this Rider applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for Vision Care Services provided under this Rider are not subject to any Annual Deductible stated in the *Schedule of Benefits*. Any amount you pay in Copayments for Vision Care Services under this Rider does not apply to the Annual Deductible stated in the *Schedule of Benefits*.

Benefit Description

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Coinsurance and Copayments stated below.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).

- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing - far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
<i>Routine Vision Examination or Refraction only in lieu of a complete exam.</i>	Once every 24 months.	100% after a Copayment of \$30 . Not subject to payment of the Annual Deductible.	50% of the billed charge.

Section 2: Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Routine Vision Examinations*, Benefits are not provided under this Rider for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the *Certificate*.

Section 3: Claims for Routine Vision Examinations

When obtaining Vision Care Services from a non-Network Vision Care Provider, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the *Certificate* in *Section 5: How to File a Claim* applies to Vision Care Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Routine Vision Examinations

To file a claim for reimbursement for Vision Care Services rendered by a non-Network Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or a non-Network Vision Care Provider), you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.

- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:

By mail:

Claims Department

P.O. Box 30978

Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Section 4: Defined Terms

The following definitions are in addition to those listed in *Section 9: Defined Terms* of the *Certificate*:

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under this Rider.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service(s) - routine vision examinations listed in this Rider in *Section 1: Benefits for Routine Vision Examinations*.

Outpatient Prescription Drug Rider

UnitedHealthcare Insurance Company

This Rider to the Policy is issued to the Enrolling Group and provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the *Certificate of Coverage (Certificate)* in *Section 9: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to UnitedHealthcare Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the *Certificate* in *Section 9: Defined Terms*.

NOTE: The Coordination of Benefits provision in the *Certificate* in *Section 7: Coordination of Benefits* applies to Prescription Drug Products covered through this Rider. Benefits for Prescription Drug Products will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in the *Certificate*.

UnitedHealthcare Insurance Company



President

Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the *Certificate* in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, and any deductible that applies.

Submit your claim to the Pharmacy Benefit Manager claims address noted on your ID card.

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List. We do not pass these rebates on to you, nor are they taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings to you or to your Physician that communicate a variety of messages, including information about Prescription Drug Products. These mailings may contain coupons or offers from pharmaceutical manufacturers that enable you, at your discretion, to purchase the described drug product at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription Order or Refill is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in your *Certificate, Section 5: How to File a Claim*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

Prescription Drug Products from a Mail Order Network Pharmacy

Benefits are provided for certain Prescription Drug Products dispensed by a mail order Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on mail order Network Pharmacy supply limits.

Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card to determine if Benefits are provided for your Prescription Drug Product and for information on how to obtain your Prescription Drug Product through a mail order Network Pharmacy.

Section 2: Exclusions

Exclusions from coverage listed in the *Certificate* apply also to this Rider, except that any preexisting condition exclusion in the *Certificate* is not applicable to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion does not include a Prescription Drug Product that has been prescribed for a specific condition or disease for which the Prescription Drug Product has not yet been approved by the *U.S. Food and Drug Administration (FDA)* if the Prescription Drug Product is recognized as safe and effective for treatment of that condition or disease for which it was prescribed in one or more of the following standard medical reference compendia:
 - *The American Medical Association Drug Evaluation.*
 - *The American Hospital Formulary Service Drug Information.*
 - *Drug Information for the Health Care Provider.*
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.
7. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression or weight loss.
9. A Pharmaceutical Product for which Benefits are provided in your *Certificate*. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Prescription Drug Products for smoking cessation, except as described under *Benefits for Prescription Drug Products* in the *Outpatient Prescription Drug Schedule of Benefits*.

18. Compounded drugs that do not contain at least one ingredient that has been approved by the *U.S. Food and Drug Administration (FDA)* and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. (Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier 4.)
19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
22. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury except for Prescription Drug Products and Special Medical Foods which are prescribed for the treatment of Genetic Inborn Errors of Metabolism.
23. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
24. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.

Section 3: Defined Terms

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.

- The following diabetic supplies:
 - standard insulin syringes with needles;
 - blood-testing strips - glucose;
 - urine-testing strips - glucose;
 - ketone-testing strips and tablets;
 - lancets and lancet devices;
 - glucose monitors;
 - injection aids, including those adaptable for the legally blind;
 - glucagon emergency kits; and
 - prescriptive oral agents for controlling blood sugar.

Prescription Order or Refill - the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible, Annual Drug Deductible or Specialty Prescription Drug Product Annual Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, selfadministered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Outpatient Prescription Drug

UnitedHealthcare Insurance Company

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits for Prescription Drug Products are available for pharmacotherapy when prescribed by a Physician for smoking cessation treatment and are limited to:

- Two 90-day courses of pharmacotherapy per Covered Person per year.

Initiation of any course of pharmacotherapy will be considered an entire course of pharmacotherapy, even if a Covered Person discontinues or fails to complete the course.

For the purposes of this Rider, "pharmacotherapy" means the use of first-line drugs, approved by the *U.S. Food and Drug Administration (FDA)* and available by prescription only, to assist in the cessation of tobacco use or smoking.

Benefits for pharmacotherapy for smoking cessation treatment are subject to all applicable requirements of this Rider.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change. You will pay the Copayment and/or Coinsurance applicable for the tier to which the Prescription Drug Product is assigned.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.

- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Non-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the *Certificate of Coverage (Certificate)* in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

If Benefits are not authorized for payment, you may appeal as described in the Certificate under *Section 6: Questions, Complaints, and Appeals*.

Step Therapy

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your *Certificate* are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your *Certificate*:

- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
<p>Copayment</p> <p>Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount.</p> <p>Coinsurance</p> <p>Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p>Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.</p> <p>Copayment and Coinsurance</p> <p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.</p> <p>Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Prescription Drug Products Prescribed by a Specialist Physician: You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. <p>For Prescription Drug Products from a mail order Network Pharmacy, you are responsible for paying the lower of the following:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Prescription Drug Charge for that Prescription Drug Product. <p>See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.</p> <p>You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.</p>

Payment Term And Description	Amounts
<p>times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.</p>	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Specialty Prescription Drug Products	
<p>The following supply limits apply.</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Specialty Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. <p>When a Specialty Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p> <p>Supply limits apply to Specialty Prescription Drug Products obtained at a Network Pharmacy, a non-Network Pharmacy, a mail order Network Pharmacy or a Designated Pharmacy.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Specialty Prescription Drug Product. All Specialty Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3, or Tier 4. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$10 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$30 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$50 per Prescription Order or Refill.</p> <p>For a Tier 4 Specialty Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$250 per Prescription Order or Refill.</p> <p>Non-Network Pharmacy</p> <p>For a Tier 1 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$10 per Prescription Order or Refill.</p> <p>For a Tier 2 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$30 per Prescription Order or Refill.</p> <p>For a Tier 3 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$50 per Prescription Order or Refill.</p> <p>For a Tier 4 Specialty Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$250 per Prescription Order or Refill.</p>
Prescription Drugs from a Retail Network Pharmacy	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug 	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3, or Tier 4. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>manufacturer's packaging size, or based on supply limits.</p> <ul style="list-style-type: none"> A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p>	<p>card to determine tier status.</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$10 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$30 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$50 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$250 per Prescription Order or Refill.</p>
Prescription Drugs from a Retail Non-Network Pharmacy	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p>	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3, or Tier 4. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$10 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$30 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$50 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: 100% of the Predominant Reimbursement Rate after you pay a Copayment of \$250 per Prescription Order or Refill.</p>
Prescription Drug Products from a Mail Order Network Pharmacy	
<p>The following supply limits apply:</p> <ul style="list-style-type: none"> As written by the provider, up to a consecutive 90-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. These supply limits do not apply to Specialty Prescription Drug Products. Specialty Prescription Drug 	<p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3, or Tier 4. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status.</p> <p>For up to a 90-day supply, we pay:</p> <p>For a Tier 1 Prescription Drug Product: 100% of the Prescription</p>

Description and Supply Limits	Benefit (The Amount We Pay)
<p>Products from a mail order Network Pharmacy are subject to the supply limits stated above under the heading <i>Specialty Prescription Drug Products</i>.</p> <p>You may be required to fill an initial Prescription Drug Product order and obtain 1 refill through a retail pharmacy prior to using a mail order Network Pharmacy.</p> <p>To maximize your Benefit, ask your Physician to write your Prescription Order or Refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copayment and/or Coinsurance for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number-of-days' supply written on the Prescription Order or Refill. Be sure your Physician writes your Prescription Order or Refill for a 90-day supply, not a 30-day supply with three refills.</p>	<p>Drug Charge after you pay a Copayment of \$25 per Prescription Order or Refill.</p> <p>For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$75 per Prescription Order or Refill.</p> <p>For a Tier 3 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$125 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$625 per Prescription Order or Refill.</p>

Important Notices under the Patient Protection and Affordable Care Act (PPACA)

Changes in Federal Law that Impact Benefits

There are changes in Federal law which may impact coverage and Benefits stated in the *Certificate of Coverage (Certificate)* and *Schedule of Benefits*. A summary of those changes and the dates the changes are effective appear below.

Patient Protection and Affordable Care Act (PPACA)

Effective for policies that are new or renewing on or after September 23, 2010, the requirements listed below apply.

- Lifetime limits on the dollar amount of essential benefits available to you under the terms of your plan are no longer permitted. In addition, any annual dollar limit applicable to the essential benefits listed below is no longer applicable. Essential benefits include the following:

Ambulatory patient services; emergency services, hospitalization; laboratory services; maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

- On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day enrollment period for those individuals who are still eligible under the plan's eligibility terms but whose coverage ended by reason of reaching a lifetime limit on the dollar value of all benefits.
- Coverage for enrolled dependent children is no longer conditioned upon full-time student status or other dependency requirements and will remain in place until the child's 26th birthday.

On or before the first day of the first plan year beginning on or after September 23, 2010, the enrolling group will provide a 30 day dependent child special open enrollment period for dependent children who are not currently enrolled under the policy and who have not yet reached age 26. During this dependent child special open enrollment period, subscribers who are adding a dependent child and who have a choice of coverage options will be allowed to change options.

- If your plan includes coverage for enrolled dependent children beyond the age of 26, which is conditioned upon full-time student status, the following applies:

Coverage for enrolled dependent children who are required to maintain full-time student status in order to continue eligibility under the policy is subject to the statute known as *Michelle's Law*. This law amends *ERISA*, the *Public Health Service Act*, and the *Internal Revenue Code* and requires group health plans, which provide coverage for dependent children who are post-secondary school students, to continue such coverage if the student loses the required student status because he or she must take a medically necessary leave of absence from studies due to a serious illness or injury.

- In-Network benefits for preventive care services described below will be paid at 100%, and not subject to any deductible, coinsurance or copayment. If you have pharmacy benefit coverage, your plan may also be required to cover preventive care medications that are obtained at a network pharmacy at 100%, and not subject to any deductible, coinsurance or copayment, as required by applicable law under any of the following:
 - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
 - Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
 - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.
 - Retroactive rescission of coverage under the policy is permitted, with 30 days advance written notice, only in the following two circumstances:
 - The individual performs an act, practice or omission that constitutes fraud.
 - The individual makes an intentional misrepresentation of a material fact.
 - Other changes provided for under the *PPACA* do not impact your plan because your plan already contains these benefits. These include:
 - Direct access to OB/GYN care without a referral or authorization requirement.
 - The ability to designate a pediatrician as a primary care physician (PCP) if your plan requires a PCP designation.
 - Prior authorization is not required before you receive services in the emergency department of a hospital.
- If you seek emergency care from out-of-network providers in the emergency department of a hospital your cost sharing obligations (copayments/coinsurance) will be the same as would be applied to care received from in-network providers.

Effective for policies that are new or renewing on or after January 1, 2014, the requirements listed below apply:

If your plan includes coverage for Clinical Trials, the following applies:

The clinical trial benefit has been modified to distinguish between clinical trials for cancer and other life threatening conditions and those for non-life threatening conditions. For trials for cancer/other life threatening conditions, routine patient costs now include those for covered individuals participating in a preventive clinical trial and Phase IV trials.

Some Important Information about Appeal and External Review Rights under PPACA

If you are enrolled in a non-grandfathered plan with an effective date or plan year anniversary on or after September 23, 2010, the *Patient Protection and Affordable Care Act of 2010 (PPACA)*, as amended, sets forth new and additional internal appeal and external review rights beyond those that some plans may have previously offered. Also, certain grandfathered plans are complying with the additional internal appeal and external review rights provisions on a voluntary basis. Please refer to your benefit plan documents, including amendments and notices, or speak with your employer or UnitedHealthcare for more information on the appeal rights available to you. (Also, please refer to the *Claims and Appeal Notice* section of this document.)

What if I receive a denial, and need help understanding it? Please call UnitedHealthcare at the number listed on the back of your health plan ID card.

What if I don't agree with the denial? You have a right to appeal any decision to not pay for an item or service.

How do I file an appeal? The initial denial letter or *Explanation of Benefits* that you receive from UnitedHealthcare will give you the information and the timeframe to file an appeal.

What if my situation is urgent? If your situation is urgent, your review will be conducted as quickly as possible. If you believe your situation is urgent, you may request an expedited review, and, if applicable, file an external review at the same time. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Generally, an urgent situation is when your health may be in serious jeopardy. Or when, in the opinion of your doctor, you may be experiencing severe pain that cannot be adequately controlled while you wait for a decision on your appeal.

Who may file an appeal? Any member or someone that member names to act as an authorized representative may file an appeal. For help call UnitedHealthcare at the number listed on the back of your health plan ID card.

Can I provide additional information about my claim? Yes, you may give us additional information supporting your claim. Send the information to the address provided in the initial denial letter or *Explanation of Benefits*.

Can I request copies of information relating to my claim? Yes. There is no cost to you for these copies. Send your request to the address provided in the initial denial letter or *Explanation of Benefits*.

What happens if I don't agree with the outcome of my appeal? If you appeal, we will review our decision. We will also send you our written decision within the time allowed. If you do not agree with the decision, you may be able to request an external review of your claim by an independent third party. If so, they will review the denial and issue a final decision.

If I need additional help, what should I do? For questions on your appeal rights, you may call UnitedHealthcare at the number listed on the back of your health plan ID card for assistance. You may also contact the support groups listed below.

Are verbal translation services available to me during an appeal? Yes. Contact UnitedHealthcare at the number listed on the back of your health plan ID card. Ask for verbal translation services for your questions.

Is there other help available to me? For questions about appeal rights, an unfavorable benefit decision, or for help, you may also contact the *Employee Benefits Security Administration* at 1-866-444-EBSA (3272). Your state consumer assistance program may also be able to help you. (<http://www.dol.gov/ebsa/healthreform/> - click link for Consumer Assistance Programs)

For information on appeals and other *PPACA* regulations, visit www.healthcare.gov.

If your plan includes coverage for Mental Health or Substance Use, the following applies:

Mental Health/Substance Use Disorder Parity

Effective for Policies that are new or renewing on or after July 1, 2010, Benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are Covered Health Services under the Policy must be treated in the same manner and provided at the same level as Covered Health Services for the treatment of other Sickness or Injury. Benefits for Mental Health Services and Substance Use Disorder Services are not subject to any annual maximum benefit limit (including any day, visit or dollar limit).

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits. MHPAEA requires specific testing to be applied to classifications of benefits to determine the impact of these financial requirements on mental health and substance use disorder benefits. Based upon the results of that testing, it is possible that coinsurance or copayments that apply to mental health conditions and substance use disorder conditions in your benefit plan may be reduced.

Women's Health and Cancer Rights Act of 1998

As required by the *Women's Health and Cancer Rights Act of 1998*, Benefits under the Policy are provided for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments, Coinsurance and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g. your Physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

Claims and Appeal Notice

This Notice is provided to you in order to describe our responsibilities under Federal law for making benefit determinations and your right to appeal adverse benefit determinations. To the extent that state law provides you with more generous timelines or opportunities for appeal, those rights also apply to you. Please refer to your benefit documents for information about your rights under state law.

Benefit Determinations

Post-service Claims

Post-service claims are those claims that are filed for payment of Benefits after medical care has been received. If your post-service claim is denied, you will receive a written notice from us within 30 days of receipt of the claim, as long as all needed information was provided with the claim. We will notify you within this 30 day period if additional information is needed to process the claim, and may request a one time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, and the claim is denied, we will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

If you have prescription drug Benefits and are asked to pay the full cost of a prescription when you fill it at a retail or mail-order pharmacy, and if you believe that it should have been paid under the Policy, you may submit a claim for reimbursement in accordance with the applicable claim filing procedures. If you pay a Copayment and believe that the amount of the Copayment was incorrect, you also may submit a claim for reimbursement in accordance with the applicable claim filing procedures. When you have filed a claim, your claim will be treated under the same procedures for post-service group health plan claims as described in this section.

Pre-service Requests for Benefits

Pre-service requests for Benefits are those requests that require notification or approval prior to receiving medical care. If you have a pre-service request for Benefits, and it was submitted properly with all needed information, we will send you written notice of the decision from us within 15 days of receipt of the request. If you filed a pre-service request for Benefits improperly, we will notify you of the improper filing and how to correct it within five days after the pre-service request for Benefits was received. If additional information is needed to process the pre-service request, we will notify you of the information needed within 15 days after it was received, and may request a one time extension not longer than 15 days and pend your request until all information is received. Once notified of the extension you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, we will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your request for Benefits will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the appeal procedures.

If you have prescription drug Benefits and a retail or mail order pharmacy fails to fill a prescription that you have presented, you may file a pre-service health request for Benefits in accordance with the applicable claim filing procedure. When you have filed a request for Benefits, your request will be treated under the same procedures for pre-service group health plan requests for Benefits as described in this section.

Urgent Requests for Benefits that Require Immediate Attention

Urgent requests for Benefits are those that require notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health, or the ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, could cause severe pain. In these situations, you will receive notice of the benefit determination in writing or electronically within 72 hours after we receive all necessary information, taking into account the seriousness of your condition.

If you filed an urgent request for Benefits improperly, we will notify you of the improper filing and how to correct it

within 24 hours after the urgent request was received. If additional information is needed to process the request, we will notify you of the information needed within 24 hours after the request was received. You then have 48 hours to provide the requested information.

You will be notified of a benefit determination no later than 48 hours after:

- Our receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an urgent request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. We will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Questions or Concerns about Benefit Determinations

If you have a question or concern about a benefit determination, you may informally contact our *Customer Care* department before requesting a formal appeal. If the *Customer Care* representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination as described above, you may appeal it as described below, without first informally contacting a *Customer Care* representative. If you first informally contact our *Customer Care* department and later wish to request a formal appeal in writing, you should again contact *Customer Care* and request an appeal. If you request a formal appeal, a *Customer Care* representative will provide you with the appropriate address.

If you are appealing an urgent claim denial, please refer to *Urgent Appeals that Require Immediate Action* below and contact our *Customer Care* department immediately.

How to Appeal a Claim Decision

If you disagree with a pre-service request for Benefits determination or post-service claim determination or a rescission of coverage determination after following the above steps, you can contact us in writing to formally request an appeal.

Your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to us within 180 days after you receive the claim denial.

Appeal Process

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field, who was not involved in the prior determination. We may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information through the submission of your appeal. Upon request and free of charge, you have the right to reasonable access to and copies of all documents, records, and other information relevant to your claim for Benefits. In addition, if any new or additional evidence is relied upon or generated by us during the determination of the appeal, we will provide it to you free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

Appeals Determinations

Pre-service Requests for Benefits and Post-service Claim Appeals

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of pre-service requests for Benefits as identified above, the first level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for appeal of a denied request for Benefits. The second level appeal will be conducted and you will be notified of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims as identified above, the first level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with urgent requests for Benefits, see *Urgent Appeals that Require Immediate Action* below.

If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal. Your second level appeal request must be submitted to us within 60 days from receipt of the first level appeal decision.

Please note that our decision is based only on whether or not Benefits are available under the Policy for the proposed treatment or procedure. The decision to obtain the proposed treatment or procedure regardless of our decision is between you and your Physician.

Urgent Appeals that Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health, or the ability to regain maximum function, or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your Physician should call us as soon as possible.
- We will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

HEALTH PLAN NOTICES OF PRIVACY PRACTICES

MEDICAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: September 23, 2013

We¹ are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by the terms of this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, the provision of health care to you, or the payment for such health care. We will comply with the requirements of applicable privacy laws relating to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we will provide to you, in our next annual distribution, either a revised notice or information about the material change and how to obtain a revised notice. We will provide you with this information either by direct mail or electronically in accordance with applicable law. In all cases, we will post the revised notice on your health plan website, such as www.myuhc.com or www.uhcwest.com. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

UnitedHealth Group collects and maintains oral, written and electronic information to administer our business and to provide products, services and information of importance to our enrollees. We maintain physical, electronic and procedural security safeguards in the handling and maintenance of our enrollee's information, in accordance with applicable state and federal standards, to protect against risks such as loss, destruction or misuse.

How We Use or Disclose Information

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice; and
- To the *Secretary of the Department of Health and Human Services*, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate our business. For example, we may use or disclose your health information:

- **For Payment** of premiums due us, to determine your coverage, and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- **For Treatment.** We may use or disclose health information to aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- **For Health Care Operations.** We may use or disclose health information as necessary to operate and manage our business activities related to providing and managing your health care coverage. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health or we may analyze data to determine how we can improve our services.
- **To Provide You Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- **For Plan Sponsors.** If your coverage is through an employer sponsored group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restrictions on its use and disclosure of the information in accordance with federal law.
- **For Underwriting Purposes.** We may use or disclose your health information for underwriting purposes; however, we will not use or disclose your genetic information for such purposes.
- **For Reminders.** We may use or disclose health information to send you reminders about your benefits or care, such as appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required to do so by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we will use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual's care. We may disclose health information to any persons involved, prior to the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- **For Public Health Activities** such as reporting or preventing disease outbreaks to a public health authority.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities that are authorized by law to receive such information, including a social service or protective service agency.
- **For Health Oversight Activities** to a health oversight agency for activities authorized by law, such as licensure, governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes.** We may disclose your health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

- **To Avoid a Serious Threat to Health or Safety** to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers' Compensation** as authorized by, or to the extent necessary to comply with, state workers compensation laws that govern job-related injuries or illness.
- **For Research Purposes** such as research related to the evaluation of certain treatments or the prevention of disease or disability, if the research study meets privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information to entities that handle procurement, banking or transplantation of organs, eyes or tissue to facilitate donation and transplantation.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under Federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information:
 - ◆ 1. HIV/AIDS;
 - ◆ 2. Mental health;
 - ◆ 3. Genetic tests;
 - ◆ 4. Alcohol and drug abuse;
 - ◆ 5. Sexually transmitted diseases and reproductive health information; and
 - ◆ 6. Child or adult abuse or neglect, including sexual assault.

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law. Attached to this notice is a "Federal and State Amendments" document.

Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited marketing communications under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, contact the phone number listed on the back of your ID card.

What Are Your Rights

The following are your rights with respect to your health information:

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health care operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with our policies, we are not required to agree to any restriction.**
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. In certain circumstances, we will accept your verbal request to receive confidential communications, however, we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you will have the right to request that we send a copy of your health information in an electronic format to you. You can also request that we provide a copy of your information to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to inspect and copy your health information or have your information sent to a third party. Mail your request to the address listed below. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for any copies.
- **You have the right to ask to amend** certain health information we maintain about you such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing and provide the reasons for the requested amendment. Mail your request to the address listed below. If we deny your request, you may have a statement of your disagreement added to your health information.
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information made: (i) for treatment, payment, and health care operations purposes; (ii) to you or pursuant to your authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. You also may obtain a copy of this notice on your health plan website, such as www.myuhc.com or www.uhcwest.com.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want information about exercising your rights, please call the toll-free member phone number on the back of your health plan ID card or you may contact the *UnitedHealth Group Customer Call Center* Representative at 866-633-2446.
- **Submitting a Written Request.** Mail to us your written requests to exercise any of your rights, including modifying or cancelling a confidential communication, for copies of your records, or requesting amendments to your record, at the following address:

UnitedHealthcare

Customer Service - Privacy Unit

PO Box 740815

Atlanta, GA 30374-0815

- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the address listed above.

You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.
We will not take any action against you for filing a complaint.

¹This Medical Information Privacy Notice applies to the following health plans that are affiliated with UnitedHealth Group: ACN Group of California, Inc.; All Savers Insurance Company; All Savers Life Insurance Company of California; AmeriChoice of Connecticut, Inc.; AmeriChoice of Georgia, Inc.; AmeriChoice of New Jersey, Inc.; Arizona Physicians IPA, Inc.; Care Improvement Plus of Maryland, Inc.; Care Improvement Plus of Texas Insurance Company; Care Improvement Plus South Central Insurance Company; Care Improvement Plus Wisconsin Insurance Company; Citrus Health Care, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Evercare of Arizona, Inc.; Golden Rule Insurance Company; Health Plan of Nevada, Inc.; MAMSI Life and Health Insurance Company; MD - Individual Practice Association, Inc.; Medical Health Plans of Florida, Inc.; Medica HealthCare Plans, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental; Optimum Choice, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; Physicians Health Choice of New York, Inc.; Physicians Health Choice of Texas, LLC; Preferred Partners, Inc.; Sierra Health and Life Insurance Company, Inc.; UHC of California; U.S. Behavioral Health Plan, California; Unimerica Insurance Company; Unimerica Life Insurance Company of New York; Unison Health Plan of Delaware, Inc.; Unison Health Plan of the Capital Area, Inc.; United Behavioral Health; UnitedHealthcare Benefits of Texas, Inc.; UnitedHealthcare Community Plan, Inc.; UnitedHealthcare Community Plan of Texas, L.L.C.; UnitedHealthcare Insurance Company; UnitedHealthcare Insurance Company of Illinois; UnitedHealthcare Insurance Company of New York; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Life Insurance Company; UnitedHealthcare of Alabama, Inc.; UnitedHealthcare of Arizona, Inc.; UnitedHealthcare of Arkansas, Inc.; UnitedHealthcare of Colorado, Inc.; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare of Kentucky, Ltd.; UnitedHealthcare of Louisiana, Inc.; UnitedHealthcare of Mid-Atlantic, Inc.; UnitedHealthcare of the Midlands, Inc.; UnitedHealthcare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of Oregon, Inc.; UnitedHealthcare of Pennsylvania, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Utah, Inc.; UnitedHealthcare of Washington, Inc.; UnitedHealthcare of Wisconsin, Inc.; UnitedHealthcare Plan of the River Valley, Inc.

FINANCIAL INFORMATION PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW FINANCIAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: September 23, 2013

We² are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and *Social Security* number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you without your authorization, to the following types of institutions:

- To our corporate affiliates, which include financial service providers, such as other insurers, and non-financial companies, such as data processors;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security

We maintain physical, electronic and procedural safeguards in accordance with applicable state and federal standards to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice

If you have any questions about this notice, please call the toll-free member phone number on the back of your health plan ID card or contact the UnitedHealth Group Customer Call Center at 866-633-2446.

²For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed in footnote 1, beginning on the last page of the Medical Information Privacy Notice, plus the following UnitedHealthcare affiliates: AmeriChoice Health Services, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; HealthAllies, Inc.; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; ProcessWorks, Inc.; Spectera, Inc.; UMR, Inc.; Unison Administrative Services, LLC; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Services, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Service LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc. This Financial Information Privacy Notice only applies where required by law. Specifically, it does not apply to (1) health care insurance products offered in Nevada by Health Plan of

Nevada, Inc. and Sierra Health and Life Insurance Company, Inc.; or (2) other UnitedHealth Group health plans in states that provide exceptions for HIPAA covered entities or health insurance products.

UNITEDHEALTH GROUP**HEALTH PLAN NOTICE OF PRIVACY PRACTICES: FEDERAL AND STATE AMENDMENTS**

Revised: June 30, 2013

The first part of this Notice, which provides our privacy practices for Medical Information, describes how we may use and disclose your health information under federal privacy rules. There are other laws that may limit our rights to use and disclose your health information beyond what we are allowed to do under the federal privacy rules. The purpose of the charts below is to:

- Show the categories of health information that are subject to these more restrictive laws; and
- Give you a general summary of when we can use and disclose your health information without your consent.

If your written consent is required under the more restrictive laws, the consent must meet the particular rules of the applicable federal or state law.

Summary of Federal Laws

Alcohol & Drug Abuse Information	
We are allowed to use and disclose alcohol and drug abuse information that is protected by federal law only (1) in certain limited circumstances, and/or disclose only (2) to specific recipients.	
Genetic Information	
We are not allowed to use genetic information for underwriting purposes.	

Summary of State Laws

General Health Information	
We are allowed to disclose general health information only (1) under certain limited circumstances, and/or (2) to specific recipients.	CA, NE, PR, RI, VT, WA, WI
HMOs must give enrollees an opportunity to approve or refuse disclosures, subject to certain exceptions.	KY
You may be able to restrict certain electronic disclosures of such health information.	NC, NV
We are not allowed to use health information for certain purposes.	CA, IA
We will not use and/or disclose information regarding certain public assistance programs except for certain purposes.	MO, NJ, SD
Prescriptions	
We are allowed to disclose prescription-related information only (1) under certain limited circumstances, and/or (2) to specific recipients.	ID, NH, NV

Communicable Diseases	
We are allowed to disclose communicable disease information only (1) under certain limited circumstances, and/or (2) to specific recipients.	AZ, IN, KS, MI, NV, OK
Sexually Transmitted Diseases and Reproductive Health	
We are allowed to disclose sexually transmitted disease and/or reproductive health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, FL, IN, KS, MI, MT, NJ, NV, PR, WA, WY
Alcohol and Drug Abuse	
We are allowed to use and disclose alcohol and drug abuse information (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.	CT, GA, KY, IL, IN, IA, LA, MN, NC, NH, WA, WI
Disclosures of alcohol and drug abuse information may be restricted by the individual who is the subject of the information.	WA
Genetic Information	
We are not allowed to disclose genetic information without your written consent.	CA, CO, IL, KS, KY, LA, NY, RI, TN, WY
We are allowed to disclose genetic information only (1) under certain limited circumstances and/or (2) to specific recipients.	AK, AZ, FL, GA, IA, MD, MA, MO, NJ, NV, NH, NM, OR, RI, TX, UT, VT
Restrictions apply to (1) the use, and/or (2) the retention of genetic information.	FL, GA, IA, LA, MD, NM, OH, UT, VA, VT
HIV / AIDS	
We are allowed to disclose HIV/AIDS-related information only (1) under certain limited circumstances and/or (2) to specific recipients.	AZ, AR, CA, CT, DE, FL, GA, IA, IL, IN, KS, KY, ME, MI, MO, MT, NH, NM, NV, NY, NC, OR, PA, PR, RI, TX, VT, WA, WV, WI, WY
Certain restrictions apply to oral disclosures of HIV/AIDS-related information.	CT, FL
Mental Health	
We are allowed to disclose mental health information only (1) under certain limited circumstances and/or (2) to specific recipients.	CA, CT, DC, IA, IL, IN, KY, MA, MI, NC, NM, PR, TN, WA, WI
Disclosures may be restricted by the individual who is the subject of the information.	WA
Certain restrictions apply to oral disclosures of mental health information.	CT
Certain restrictions apply to the use of mental health information.	ME

Child or Adult Abuse

We are allowed to use and disclose child and/or adult abuse information only (1) under certain limited circumstances, and/or disclose only (2) to specific recipients.

AL, CO, IL, LA, NE, NJ, NM, RI, TN, TX, UT, WI

Statement of Employee Retirement Income Security Act of 1974 (ERISA) Rights

As a participant in the plan, you are entitled to certain rights and protections under the *Employee Retirement Income Security Act of 1974 (ERISA)*.

Receive Information about Your Plan and Benefits

You are entitled to examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the *U.S. Department of Labor* and available at the *Public Disclosure Room* of the *Employee Benefits Security Administration*.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated *Summary Plan Description*. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

You are entitled to continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. The Plan Sponsor is responsible for providing you notice of your *Consolidated Omnibus Budget Reconciliation Act (COBRA)* continuation rights. Review the *Summary Plan Description* and the documents governing the plan on the rules governing your *COBRA* continuation coverage rights.

You are entitled to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another group health plan. You should be provided a certificate of creditable coverage, in writing, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect *COBRA* continuation coverage, when your *COBRA* continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. You may request a certificate of creditable coverage by calling the number on the back of your ID card. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, *ERISA* imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under *ERISA*.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the *U.S. Department of Labor*, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you

lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the *Employee Benefits Security Administration, U.S. Department of Labor* listed in your telephone directory or the *Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor*, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under *ERISA* by calling the publication hotline of the *Employee Benefits Security Administration*.

EXHIBIT E

Summary Plan Description

Taft Stettinius & Hollister LLP Choice Plus HRA Plan

Effective: June 1, 2015

Group Number: 729530



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SECTION 1 - WELCOME

Quick Reference Box

- Member services, claim inquiries, Personal Health Support and Mental Health/Substance Use Disorder Administrator: (866) 314-0335;
- Claims submittal address: UnitedHealthcare - Claims, P.O. Box 30555, Salt Lake City, Utah 84130-0555; and
- Online assistance: www.myuhc.com.

Taft Stettinius & Hollister LLP is pleased to provide you with this Summary Plan Description (SPD), which describes the health Benefits available to you and your covered family members under the Taft Stettinius & Hollister LLP Welfare Benefit Plan. It includes summaries of:

- who is eligible;
- services that are covered, called Covered Health Services;
- services that are not covered, called Exclusions;
- how Benefits are paid; and
- your rights and responsibilities under the Plan.

This SPD is designed to meet your information needs and the disclosure requirements of the Employee Retirement Income Security Act of 1974 (ERISA). It supersedes any previous printed or electronic SPD for this Plan.

IMPORTANT

The healthcare service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in Section 14, *Glossary*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance use disorder, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under the Plan.

Taft Stettinius & Hollister LLP intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, and without prior notice. This SPD is not to be construed as a contract of or for employment. If there should be an inconsistency between the contents of this summary and the contents of the Plan, your rights shall be determined under the Plan and not under this summary.

UnitedHealthcare is a private healthcare claims administrator. UnitedHealthcare's goal is to give you the tools you need to make wise healthcare decisions. UnitedHealthcare also helps your employer to administer claims. Although UnitedHealthcare will assist you in many

ways, it does not guarantee any Benefits. Taft Stettinius & Hollister LLP is solely responsible for paying Benefits described in this SPD.

Please read this SPD thoroughly to learn how the Taft Stettinius & Hollister LLP Welfare Benefit Plan works. If you have questions contact your local Human Resources department or call the number on the back of your ID card.

How To Use This SPD

- Read the entire SPD, and share it with your family. Then keep it in a safe place for future reference.
- Many of the sections of this SPD are related to other sections. You may not have all the information you need by reading just one section.
- You can find copies of your SPD and any future amendments or request printed copies by contacting Human Resources.
- Capitalized words in the SPD have special meanings and are defined in Section 14, *Glossary*.
- If eligible for coverage, the words "you" and "your" refer to Covered Persons as defined in Section 14, *Glossary*.
- Taft Stettinius & Hollister LLP is also referred to as Company.
- If there is a conflict between this SPD and any benefit summaries (other than Summaries of Material Modifications) provided to you, this SPD will control.

SECTION 2 - INTRODUCTION

What this section includes:

- Who's eligible for coverage under the Plan;
- The factors that impact your cost for coverage;
- Instructions and timeframes for enrolling yourself and your eligible Dependents;
- When coverage begins; and
- When you can make coverage changes under the Plan.

Eligibility

You are eligible to enroll in the Plan if you are a regular full-time employee who is scheduled to work at least 18.75 hours per week or a person who retires while covered under the Plan.

Your eligible Dependents may also participate in the Plan. An eligible Dependent is considered to be:

- your Spouse, as defined in Section 14, *Glossary*;
- your or your Spouse's child who is under age 28, including a natural child, stepchild, a legally adopted child, a child placed for adoption or a child for whom you or your Spouse are the legal guardian; or
- an unmarried child age 28 or over who is or becomes disabled and dependent upon you.

To be eligible for coverage under the Plan, a Dependent must reside within the United States.

Note: Your Dependents may not enroll in the Plan unless you are also enrolled. If you and your Spouse are both covered under the Taft Stettinius & Hollister LLP Welfare Benefit Plan, you may each be enrolled as a Participant or be covered as a Dependent of the other person, but not both. In addition, if you and your Spouse are both covered under the Taft Stettinius & Hollister LLP Welfare Benefit Plan, only one parent may enroll your child as a Dependent.

A Dependent also includes a child for whom health care coverage is required through a Qualified Medical Child Support Order or other court or administrative order, as described in Section 13, *Other Important Information*.

Cost of Coverage

You and Taft Stettinius & Hollister LLP share in the cost of the Plan. Your contribution amount depends on the Plan you select and the family members you choose to enroll.

Your contributions are deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld -

and in most states, before state and local taxes are withheld. This gives your contributions a special tax advantage and lowers the actual cost to you.

Note: The Internal Revenue Service generally does not consider Domestic Partners and their children eligible Dependents. Therefore, the value of Taft Stettinius & Hollister LLP's cost in covering a Domestic Partner may be imputed to the Participant as income. In addition, the share of the Participant's contribution that covers a Domestic Partner and their children may be paid using after-tax payroll deductions.

Your contributions are subject to review and Taft Stettinius & Hollister LLP reserves the right to change your contribution amount from time to time.

You can obtain current contribution rates by calling Human Resources.

How to Enroll

To enroll, call Human Resources within 31 days of the date you first become eligible for medical Plan coverage. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to make your benefit elections.

Each year during annual Open Enrollment, you have the opportunity to review and change your medical election. Any changes you make during Open Enrollment will become effective the following June 1.

Important

If you wish to change your benefit elections following your marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources within 31 days of the event. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

When Coverage Begins

Once Human Resources receives your properly completed enrollment, coverage will begin on the first day of the month following your date of hire, or if your date of hire is on the first day of the month, coverage will begin on that day. Coverage for your Dependents will start on the date your coverage begins, provided you have enrolled them in a timely manner.

Coverage for a Spouse or Dependent stepchild that you acquire via marriage becomes effective the first of the month following the date Human Resources receives notice of your marriage, provided you notify Human Resources within 31 days of your marriage. Coverage for Dependent children acquired through birth, adoption, or placement for adoption is effective the date of the family status change, provided you notify Human Resources within 31 days of the birth, adoption, or placement.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, the Plan will pay Benefits for Covered Health Services related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of the Plan.

You should notify UnitedHealthcare within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Changing Your Coverage

You may make coverage changes during the year only if you experience a change in family status. The change in coverage must be consistent with the change in status (e.g., you cover your Spouse following your marriage, your child following an adoption, etc.). The following are considered family status changes for purposes of the Plan:

- your marriage, divorce, legal separation or annulment;
- registering a Domestic Partner;
- the birth, adoption, placement for adoption or legal guardianship of a child;
- a change in your Spouse's employment or involuntary loss of health coverage (other than coverage under the Medicare or Medicaid programs) under another employer's plan;
- loss of coverage due to the exhaustion of another employer's COBRA benefits, provided you were paying for premiums on a timely basis;
- the death of a Dependent;
- your Dependent child no longer qualifying as an eligible Dependent;
- a change in your or your Spouse's position or work schedule that impacts eligibility for health coverage;
- contributions were no longer paid by the employer (This is true even if you or your eligible Dependent continues to receive coverage under the prior plan and to pay the amounts previously paid by the employer);
- you or your eligible Dependent who were enrolled in an HMO no longer live or work in that HMO's service area and no other benefit option is available to you or your eligible Dependent;
- benefits are no longer offered by the Plan to a class of individuals that include you or your eligible Dependent;
- termination of your or your Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage as a result of loss of eligibility (you must contact Human Resources within 60 days of termination);
- you or your Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP (you must contact Human Resources within 60 days of determination of subsidy eligibility);
- a strike or lockout involving you or your Spouse; or
- a court or administrative order.

Unless otherwise noted above, if you wish to change your elections, you must contact Human Resources within 31 days of the change in family status. Otherwise, you will need to wait until the next annual Open Enrollment.

While some of these changes in status are similar to qualifying events under COBRA, you, or your eligible Dependent, do not need to elect COBRA continuation coverage to take advantage of the special enrollment rights listed above. These will also be available to you or your eligible Dependent if COBRA is elected.

Note: Any child under age 28 who is placed with you for adoption will be eligible for coverage on the date the child is placed with you, even if the legal adoption is not yet final. If you do not legally adopt the child, all medical Plan coverage for the child will end when the placement ends. No provision will be made for continuing coverage (such as COBRA coverage) for the child.

Change in Family Status - Example

Jane is married and has two children who qualify as Dependents. At annual Open Enrollment, she elects not to participate in Taft Stettinius & Hollister LLP's medical plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, Tom loses his job as part of a downsizing. As a result, Tom loses his eligibility for medical coverage. Due to this family status change, Jane can elect family medical coverage under Taft Stettinius & Hollister LLP's medical plan outside of annual Open Enrollment.

SECTION 3 - HOW THE PLAN WORKS

What this section includes:

- Network and Non-Network Benefits;
- Eligible Expenses;
- Annual Deductible;
- Coinsurance; and
- Out-of-Pocket Maximum.

Network and Non-Network Benefits

As a participant in this Plan, you have the freedom to choose the Physician or health care professional you prefer each time you need to receive Covered Health Services. The choices you make affect the amounts you pay, as well as the level of Benefits you receive and any benefit limitations that may apply.

You are eligible for the Network level of Benefits under this Plan when you receive Covered Health Services from Physicians and other health care professionals who have contracted with UnitedHealthcare to provide those services.

You can choose to receive Network Benefits or Non-Network Benefits.

Network Benefits apply to Covered Health Services that are provided by a Network Physician or other Network provider. Emergency Health Services are always paid as Network Benefits. For facility charges, these are Benefits for Covered Health Services that are billed by a Network facility and provided under the direction of either a Network or non-Network Physician or other provider. Network Benefits include Physician services provided in a Network facility by a Network or a non-Network radiologist, anesthesiologist, pathologist and Emergency room Physician.

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility.

Generally, when you receive Covered Health Services from a Network provider, you pay less than you would if you receive the same care from a non-Network provider. Therefore, in most instances, your out-of-pocket expenses will be less if you use a Network provider.

If you choose to seek care outside the Network, the Plan generally pays Benefits at a lower level. You are required to pay the amount that exceeds the Eligible Expense. The amount in excess of the Eligible Expense could be significant, and this amount does not apply to the Out-of-Pocket Maximum. You may want to ask the non-Network provider about their billed charges before you receive care.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible to receive Network Benefits from a non-Network provider. In this situation, your Network Physician will notify Personal Health Support, and they will work with you and your Network Physician to coordinate care through a non-Network provider.

When you receive Covered Health Services through a Network Physician, the Plan will pay Network Benefits for those Covered Health Services, even if one or more of those Covered Health Services is received from a non-Network provider.

Looking for a Network Provider?

In addition to other helpful information, www.myuhc.com, UnitedHealthcare's consumer website, contains a directory of health care professionals and facilities in UnitedHealthcare's Network. While Network status may change from time to time, www.myuhc.com has the most current source of Network information. Use www.myuhc.com to search for Physicians available in your Plan.

Network Providers

UnitedHealthcare or its affiliates arrange for health care providers to participate in a Network. At your request, UnitedHealthcare will send you a directory of Network providers free of charge. Keep in mind, a provider's Network status may change. To verify a provider's status or request a provider directory, you can call UnitedHealthcare at the toll-free number on your ID card or log onto www.myuhc.com.

Network providers are independent practitioners and are not employees of Taft Stettinius & Hollister LLP or UnitedHealthcare.

UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Possible Limitations on Provider Use

If UnitedHealthcare determines that you are using health care services in a harmful or abusive manner, you may be required to select a Network Physician to coordinate all of your future Covered Health Services. If you don't make a selection within 31 days of the date you are notified, UnitedHealthcare will select a Network Physician for you. In the event that you do not use the Network Physician to coordinate all of your care, any Covered Health Services you receive will be paid at the non-Network level.

Eligible Expenses

Eligible Expenses are charges for Covered Health Services that are provided while the Plan is in effect, determined according to the definition in Section 14, *Glossary*. For certain Covered Health Services, the Plan will not pay these expenses until you have met your Annual Deductible. Taft Stettinius & Hollister LLP has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses

Taft Stettinius & Hollister LLP has delegated to UnitedHealthcare the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be determined and otherwise covered under the Plan.

Eligible Expenses are the amount UnitedHealthcare determines that UnitedHealthcare will pay for Benefits. For Network Benefits, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount UnitedHealthcare will pay for Eligible Expenses. Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines, as described in the SPD.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are UnitedHealthcare's contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as a result of an Emergency or as arranged by UnitedHealthcare, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Non-Network Benefits, Eligible Expenses are based on either of the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either UnitedHealthcare or one of UnitedHealthcare's vendors, affiliates or subcontractors, at UnitedHealthcare's discretion.
 - If rates have not been negotiated, then one of the following amounts:
 - ◆ Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market.
 - ◆ When a rate is not published by *CMS* for the service, UnitedHealthcare uses an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, UnitedHealthcare uses a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to UnitedHealthcare's website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - For Pharmaceutical Products, UnitedHealthcare uses gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based

on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

- When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

- ◆ For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

UnitedHealthcare updates the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

- When Covered Health Services are received from a Network provider, Eligible Expenses are *UnitedHealthcare's* contracted fee(s) with that provider.

Don't Forget Your ID Card

Remember to show your *UnitedHealthcare* ID card every time you receive health care services from a provider. If you do not show your ID card, a provider has no way of knowing that you are enrolled under the Plan.

Annual Deductible

The Annual Deductible is the amount of Eligible Expenses you must pay each plan year for Covered Health Services before you are eligible to begin receiving Benefits. There are separate Network and non-Network Annual Deductibles for this Plan. The amounts you pay toward your Annual Deductible accumulate over the course of the plan year.

Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum benefit limit. As a result, the limited benefit will be reduced by the number of days or visits you used toward meeting the Annual Deductible.

~~When a Covered Person was previously covered under a benefit plan that was replaced by the Plan, any amount already applied to that annual deductible provision of the prior plan will apply to the Annual Deductible provision under this Plan.~~

Coinsurance

Coinsurance is the percentage of Eligible Expenses that you are responsible for paying. Coinsurance is a fixed percentage that applies to certain Covered Health Services after you meet the Annual Deductible.

Coinsurance – Example

Let's assume that you receive Plan Benefits for outpatient surgery from a Network provider. Since the Plan pays 90% after you meet the Annual Deductible, you are responsible for paying the other 10%. This 10% is your Coinsurance.

Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the most you pay each plan year for Covered Health Services. There are separate Network and non-Network Out-of-Pocket Maximums for this Plan. If your eligible out-of-pocket expenses in a plan year exceed the annual maximum, the Plan pays 100% of Eligible Expenses for Covered Health Services through the end of the plan year.

The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 15, *Outpatient Prescription Drugs*.

The following table identifies what does and does not apply toward your Network and non-Network Out-of-Pocket Maximums:

Plan Features	Applies to the Network Out-of-Pocket Maximum?	Applies to the Non-Network Out-of-Pocket Maximum?
Copays for Covered Health Services available in Section 15, <i>Prescription Drugs</i>	Yes	Yes
Payments toward the Annual Deductible	Yes	Yes
Coinsurance Payments	Yes	Yes
Charges for non-Covered Health Services	No	No
The amounts of any reductions in Benefits you incur by not obtaining prior authorization from Personal Health Support	No	No
Charges that exceed Eligible Expenses	No	No

SECTION 4 - PERSONAL HEALTH SUPPORT

What this section includes:

- An overview of the Personal Health Support program; and
- Covered Health Services for which you need to contact Personal Health Support.

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents.

Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.

If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being.

Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice. As of the publication of this SPD, the Personal Health Support Nurse program includes:

- **Admission counseling** - For upcoming inpatient Hospital admissions for certain conditions, a Treatment Decision Support Nurse may call you to help answer your questions and to make sure you have the information and support you need for a successful recovery.
- **Inpatient care management** - If you are hospitalized, a nurse will work with your Physician to make sure you are getting the care you need and that your Physician's treatment plan is being carried out effectively.
- **Readmission Management** - This program serves as a bridge between the Hospital and your home if you are at high risk of being readmitted. After leaving the Hospital, if you have a certain chronic or complex condition, you may receive a phone call from a Personal Health Support Nurse to confirm that medications, needed equipment, or follow-up services are in place. The Personal Health Support Nurse will also share important health care information, reiterate and reinforce discharge instructions, and support a safe transition home.
- **Risk Management** - Designed for participants with certain chronic or complex conditions, this program addresses such health care needs as access to medical specialists, medication information, and coordination of equipment and supplies. Participants may receive a phone call from a Personal Health Support Nurse to discuss

and share important health care information related to the participant's specific chronic or complex condition.

If you do not receive a call from a Personal Health Support Nurse but feel you could benefit from any of these programs, please call the toll-free number on your ID card.

Prior Authorization

UnitedHealthcare requires prior authorization for certain Covered Health Services. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. Services for which prior authorization is required are identified below and in Section 6, *Additional Coverage Details* within each Covered Health Service category.

It is recommended that you confirm with UnitedHealthcare that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact UnitedHealthcare to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact UnitedHealthcare by calling the toll-free telephone number on the back of your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers.

To obtain prior authorization, call the toll-free telephone number on the back of your ID card. This call starts the utilization review process. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization is required even if you have a referral from your Primary Physician to seek care from another Network Physician.

Network providers are generally responsible for obtaining prior authorization from Personal Health Support before they provide certain services to you. However, there are some

Network Benefits for which you are responsible for obtaining prior authorization from Personal Health Support.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization from Personal Health Support before you receive these services. In many cases, your Non-Network Benefits will be reduced if Personal Health Support has not provided prior authorization.

The services that require Personal Health Support authorization are:

- ambulance – non-emergent air and ground;
- Clinical Trials;
- Congenital Heart Disease services;
- dental services - accident only;
- Durable Medical Equipment for items that will cost more than \$1,000 to purchase or rent, including diabetes equipment for the management and treatment of diabetes;
- Genetic Testing – BRCA;
- home health care;
- hospice care - inpatient;
- Hospital Inpatient Stay;
- manipulative treatment as described under *Rehabilitation Services - Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;
- maternity care that exceeds the delivery timeframes as described in Section 6, *Additional Coverage Details*;
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Neurobiological Disorders - **Mental Health Services for Autism Spectrum Disorder Services** - inpatient services (including Partial Hospitalization/Day treatment and services at a Residential Treatment Facility); intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;
- Reconstructive Procedures, including breast reconstruction surgery following mastectomy;
- Skilled Nursing Facility/Inpatient Rehabilitation Facility Services;
- Substance Use Disorder Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility);

intensive outpatient program treatment; outpatient electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management;

- Surgery - diagnostic catheterization and electrophysiology implant and sleep apnea surgeries as described under *Surgery - Outpatient* in Section 6, *Additional Coverage Details*;
- Therapeutics - outpatient dialysis treatments, intensity modulated radiation therapy and MR-guided focused ultrasound as described under *Therapeutic Treatments - Outpatient* in Section 6, *Additional Coverage Details*; and
- transplantation services.

Notification is required within one business day of admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital as a result of an Emergency.

For prior authorization timeframes, and reductions in Benefits that apply if you do not obtain prior authorization from Personal Health Support, see Section 6, *Additional Coverage Details*.

<p>Contacting Personal Health Support is easy. Simply call the toll-free number on your ID card.</p>

Special Note Regarding Medicare

If you are enrolled in Medicare on a primary basis and Medicare pays benefits before the Plan, you are not required to receive prior authorization from Personal Health Support before receiving Covered Health Services. Since Medicare pays benefits first, the Plan will pay Benefits second as described in Section 10, *Coordination of Benefits (COB)*.

SECTION 5 - PLAN HIGHLIGHTS

The table below provides an overview of the Plan's Annual Deductible and Out-of-Pocket Maximum.

Plan Features	Network	Non-Network
Annual Deductible¹		
■ Individual	\$3,000	\$3,000
■ Family (cumulative Annual Deductible ²)	\$6,000	\$6,000
Annual Out-of-Pocket Maximum		
■ Individual	\$4,000	\$6,000
■ Family (cumulative Out-of-Pocket Maximum ³)	\$8,000	\$12,000
Lifetime Maximum Benefit⁴ There is no dollar limit to the amount the Plan will pay for essential Benefits during the entire period you are enrolled in this Plan.	Unlimited	

¹The Annual Deductible applies toward the Out-of-Pocket Maximum for all Covered Health Services.

²The Plan does not require that you or a covered Dependent meet the individual Deductible in order to satisfy the family Deductible. If more than one person in a family is covered under the Plan, the individual coverage Deductible stated in the table above does not apply. Instead, the family Deductible applies and no one in the family is eligible to receive Benefits until the family Deductible is satisfied.

³The Plan does not require that you or a covered Dependent meet the individual Out-of-Pocket Maximum in order to satisfy the Out-of-Pocket Maximum. If more than one person in a family is covered under the Plan, the individual coverage Out-of-Pocket Maximum stated in the table above does not apply. Instead, for family coverage the family Out-of-Pocket Maximum applies.

⁴Generally the following are considered to be essential benefits under the Patient Protection and Affordable Care Act:

Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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This table provides an overview of the Plan's coverage levels. For detailed descriptions of your Benefits, refer to Section 6, *Additional Coverage Details*.

Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Ambulance Services ■ Emergency Ambulance ■ Non-Emergency Ambulance	90% after you meet the Annual Deductible 90% after you meet the Annual Deductible	90% after you meet the Annual Deductible 90% after you meet the Annual Deductible
Cancer Resource Services (CRS)² ■ Hospital Inpatient Stay	90% after you meet the Annual Deductible	Not Covered
Clinical Trials	Depending upon where the Covered Health Service is provided, Benefits for Clinical Trials will be the same as those stated under each Covered Health Service category in this section.	
Congenital Heart Disease (CHD) Surgeries ■ Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Dental Services - Accident Only	90% after you meet the Annual Deductible	90% after you meet the Annual Deductible
Diabetes Services Diabetes Self-Management and Training/ Diabetic Eye Examinations/Foot Care	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be paid the same as those stated under each Covered Health Service category in this section.	

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Diabetes Self-Management Items See <i>Durable Medical Equipment</i> in Section 6, <i>Additional Coverage Details</i> , for limits	Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> in this section and in Section 15, <i>Prescription Drugs</i> .	
Durable Medical Equipment (DME) See Section 6, <i>Additional Coverage Details</i> , for limits.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Emergency Health Services - Outpatient	90% after you meet the Annual Deductible	
Hearing Aids Up to \$4,000 per plan year	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Home Health Care Up to 100 visits per plan year	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospice Care	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Hospital - Inpatient Stay	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Kidney Resource Services (KRS) (These Benefits are for Covered Health Services provided through KRS only)	90% after you meet the Annual Deductible	Not Covered
Lab, X-Ray and Diagnostics - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Mental Health Services <ul style="list-style-type: none"> ■ Hospital - Inpatient Stay ■ Physician's Office Services 	90% after you meet the Annual Deductible 90% after you meet the Annual Deductible	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Neurobiological Disorders - Mental Health Services for Autism Spectrum Disorder Services <ul style="list-style-type: none"> ■ Hospital - Inpatient Stay ■ Physician's Office Services 	90% after you meet the Annual Deductible 90% after you meet the Annual Deductible	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Ostomy Supplies	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pharmaceutical Products - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician Fees for Surgical and Medical Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Physician's Office Services - Sickness and Injury	90% and after you meet the Annual Deductible	70% after you meet the Annual Deductible
Pregnancy - Maternity Services A Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.	Benefits will be the same as those stated under each Covered Health Service category in this section.	

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
Preventive Care Services <ul style="list-style-type: none"> ■ Physician Office Services ■ Lab, X-ray or Other Preventive Tests ■ Breast Pumps 	100% 100% 100%	70% after you meet the Annual Deductible 70% after you meet the Annual Deductible 70% after you meet the Annual Deductible
Prosthetic Devices See Section 6, <i>Additional Coverage Details</i> , for visit limits	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Reconstructive Procedures	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this section.	
Rehabilitation Services - Outpatient Therapy and Manipulative Treatment See Section 6, <i>Additional Coverage Details</i> , for visit limits	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Scopic Procedures - Outpatient Diagnostic and Therapeutic	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Skilled Nursing Facility/Inpatient Rehabilitation Facility Services Up to 100 days per plan year	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Substance Use Disorder Services <ul style="list-style-type: none"> ■ Hospital - Inpatient Stay ■ Physician's Office Services 	90% after you meet the Annual Deductible 90% after you meet the Annual	70% after you meet the Annual Deductible 70% after you meet the Annual

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Covered Health Services ¹	Percentage of Eligible Expenses Payable by the Plan:	
	Network	Non-Network
	Deductible	Deductible
Surgery - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Therapeutic Treatments - Outpatient	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Transplantation Services	Depending upon where the Covered Health Services is provided, Benefits for transplantation services will be the same as those stated under each Covered Health Services category in this section.	
Travel and Lodging (If services rendered by a Designated Facility)	For patient and companion(s) of patient undergoing cancer, Congenital Heart Disease treatment or transplant procedures	
Urgent Care Center Services	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible
Vision Examinations Up to 1 exam per plan year.	90% after you meet the Annual Deductible	70% after you meet the Annual Deductible

¹You must obtain prior authorization from Personal Health Support, as described in Section 4, *Personal Health Support* to receive full Benefits before receiving certain Covered Health Services from a non-Network provider. In general, if you visit a Network provider, that provider is responsible for obtaining prior authorization from Personal Health Support before you receive certain Covered Health Services. See Section 6, *Additional Coverage Details* for further information.

²These Benefits are for Covered Health Services provided through CRS at a Designated Facility. For oncology services not provided through CRS, the Plan pays Benefits as described under *Physician's Office Services, Physician Fees for Surgical and Medical Services, Hospital - Inpatient Stay, Surgery - Outpatient, Scopic Procedures - Outpatient Diagnostic and Therapeutic Lab, X-Ray and Diagnostics - Outpatient, and Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA and Nuclear Medicine - Outpatient.*

SECTION 6 - ADDITIONAL COVERAGE DETAILS

What this section includes:

- Covered Health Services for which the Plan pays Benefits; and
- Covered Health Services that require you to obtain prior authorization from Personal Health Support before you receive them, and any reduction in Benefits that may apply if you do not call Personal Health Support.

This section supplements the second table in Section 5, *Plan Highlights*.

While the table provides you with Benefit limitations along with Coinsurance and Annual Deductible information for each Covered Health Service, this section includes descriptions of the Benefits. These descriptions include any additional limitations that may apply, as well as Covered Health Services for which you must call Personal Health Support. The Covered Health Services in this section appear in the same order as they do in the table for easy reference. Services that are not covered are described in Section 8, *Exclusions*.

Ambulance Services

The Plan covers Emergency ambulance services and transportation provided by a licensed ambulance service to the nearest Hospital that offers Emergency Health Services. See Section 14, *Glossary* for the definition of Emergency.

Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy. If special circumstances exist, UnitedHealthcare may pay Benefits for Emergency air transportation to a Hospital that is not the closest facility to provide Emergency Health Services.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities when the transport is:

- from a non-Network Hospital to a Network Hospital;
- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting.

In most cases, UnitedHealthcare will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, please remember that you must obtain prior authorization from Personal Health Support as soon as possible prior to the transport. If authorization from Personal Health Support is not obtained, you will be responsible for paying all charges and no Benefits will be paid.

Cancer Resource Services (CRS)

The Plan pays Benefits for oncology services provided by Designated Facilities participating in the Cancer Resource Services (CRS) program. Designated Facility is defined in Section 14, *Glossary*.

For oncology services and supplies to be considered Covered Health Services, they must be provided to treat a condition that has a primary or suspected diagnosis relating to cancer. If you or a covered Dependent has cancer, you may:

- be referred to CRS by a Personal Health Support Nurse;
- call CRS toll-free at (866) 936-6002; or
- visit www.myoptumhealthcomplexmedical.com.

To receive Benefits for a cancer-related treatment, you are not required to visit a Designated Facility. If you receive oncology services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury;*
- *Physician Fees for Surgical and Medical Services;*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic;*
- *Therapeutic Treatments - Outpatient;*
- *Hospital - Inpatient Stay; and*
- *Surgery - Outpatient.*

To receive Benefits under the CRS program, you must contact CRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the CRS program if CRS provides the proper authorization to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted;
- cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below;
- surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below; and

- other diseases or disorders which are not life threatening for which, as UnitedHealthcare determines, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial;
- Covered Health Services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; and
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include:

- the Experimental or Investigational Service or item. The only exceptions to this are:
 - certain Category B devices;
 - certain promising interventions for patients with terminal illnesses; and
 - other items and services that meet specified criteria in accordance with our medical and drug policies;
- items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine and hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

- *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*);
 - *Centers for Disease Control and Prevention (CDC)*;
 - *Agency for Healthcare Research and Quality (AHRQ)*;
 - *Centers for Medicare and Medicaid Services (CMS)*;
 - a cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*;
 - a qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants; or
 - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ◆ comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*; and
 - ◆ ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- the study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*;
 - the study or investigation is a drug trial that is exempt from having such an investigational new drug application;
 - the clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. UnitedHealthcare may, at any time, request documentation about the trial; or
 - the subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under the Plan.

Please remember that you must obtain prior authorization from Personal Health Support as soon as the possibility of participation in a Clinical Trial arises. For Non-Network Benefits, if authorization from Personal Health Support is not obtained, Benefits for Covered Health Services will be reduced to 50% of Eligible Expenses not to exceed \$500.

Congenital Heart Disease (CHD) Surgeries

The Plan pays Benefits for Congenital Heart Disease (CHD) services ordered by a Physician and received at a CHD Resource Services program. Benefits include the facility charge and the charge for supplies and equipment. Benefits are available for the following CHD services:

- outpatient diagnostic testing;
- evaluation;
- surgical interventions;
- interventional cardiac catheterizations (insertion of a tubular device in the heart);

- fetal echocardiograms (examination, measurement and diagnosis of the heart using ultrasound technology); and
- approved fetal interventions.

CHD services other than those listed above are excluded from coverage, unless determined by United Resource Networks or Personal Health Support to be proven procedures for the involved diagnoses. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the toll-free number on your ID card for information about CHD services.

If you receive Congenital Heart Disease services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury;*
- *Physician Fees for Surgical and Medical Services;*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic;*
- *Therapeutic Treatments - Outpatient;*
- *Hospital - Inpatient Stay; and*
- *Surgery - Outpatient.*

Please remember for Non-Network Benefits, you must obtain prior authorization from United Resource Networks or Personal Health Support as soon as CHD is suspected or diagnosed. If authorization from United Resource Networks or Personal Health Support is not obtained, Benefits for Covered Health Services will be reduced to 50% of Eligible Expenses not to exceed \$500.

Dental Services - Accident Only

Dental services are covered by the Plan when all of the following are true:

- treatment is necessary because of accidental damage;
- dental damage does not occur as a result of normal activities of daily living or extraordinary use of the teeth;
- dental services are received from a Doctor of Dental Surgery or a Doctor of Medical Dentistry; and
- the dental damage is severe enough that initial contact with a Physician or dentist occurs within 72 hours of the accident. (You may request an extension of this time period provided that you do so within 60 days of the Injury and if extenuating circumstances exist due to the severity of the Injury.)

The Plan also covers dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition limited to:

- dental services related to medical transplant procedures;
- initiation of immunosuppressives (medication used to reduce inflammation and suppress the immune system); and
- direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental services for final treatment to repair the damage caused by accidental Injury must be started within three months of the accident unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care) and completed within 12 months of the accident.

The Plan pays for treatment of accidental Injury only for:

- emergency examination;
- necessary diagnostic x-rays;
- endodontic (root canal) treatment;
- temporary splinting of teeth;
- prefabricated post and core;
- simple minimal restorative procedures (fillings);
- extractions;
- post-traumatic crowns if such are the only clinically acceptable treatment; and
- replacement of lost teeth due to the Injury by implant, dentures or bridges.

Please remember that you should obtain prior authorization from Personal Health Support as soon as possible, but at least five business days before follow-up (post-Emergency) treatment begins. You do not have to obtain authorization before the initial Emergency treatment. When you obtain authorization, Personal Health Support can determine whether the service is a Covered Health Service.

Diabetes Services

The Plan pays Benefits for the Covered Health Services identified below.

Covered Diabetes Services	
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	<p>Benefits include outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. These services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals.</p> <p>Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes.</p>

Covered Diabetes Services	
Diabetic Self-Management Items	<p>Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under <i>Durable Medical Equipment</i> in this section.</p> <p>Benefits for blood glucose monitors, insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are described in Section 15, <i>Prescription Drugs</i>.</p> <p>Benefits for diabetes equipment that meet the definition of Durable Medical Equipment are not subject to the limit stated under <i>Durable Medical Equipment</i> in this section.</p>

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support before obtaining any Durable Medical Equipment for the management and treatment of diabetes if the retail purchase cost or cumulative retail rental cost of a single item will exceed \$1,000. You must purchase or rent the DME from the vendor Personal Health Support identifies. If authorization from Personal Health Support is not obtained, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

Durable Medical Equipment (DME)

The Plan pays for Durable Medical Equipment (DME) that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example: one insulin pump) and for repairs of that unit.

Examples of DME include but are not limited to:

- equipment to administer oxygen;
- equipment to assist mobility, such as a standard wheelchair;

- Hospital beds;
- delivery pumps for tube feedings;
- negative pressure wound therapy pumps (wound vacuums);
- burn garments;
- insulin pumps and all related necessary supplies as described under *Diabetes Services* in this section;
- external cochlear devices and systems. Surgery to place a cochlear implant is also covered by the Plan. Cochlear implantation can either be an inpatient or outpatient procedure. See *Hospital - Inpatient Stay*, *Rehabilitation Services - Outpatient Therapy* and *Surgery - Outpatient* in this section;
- braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices and are excluded from coverage. Dental braces are also excluded from coverage; and
- equipment for the treatment of chronic or acute respiratory failure or conditions.

The Plan also covers tubings, nasal cannulas, connectors and masks used in connection with DME.

Benefits also include speech aid devices and tracheo-esophageal voice devices required for treatment of severe speech impediment or lack of speech directly attributed to Sickness or Injury. Benefits for the purchase of speech aid devices and tracheo-esophageal voice devices are available only after completing a required three-month rental period. Benefits are limited as stated below.

Note: DME is different from prosthetic devices – see *Prosthetic Devices* in this section.

Benefits for speech aid devices and tracheo-esophageal voice devices are limited to the purchase of one device during the entire period of time a Covered Person is enrolled under the Plan.

Benefits are provided for the repair/replacement of a type of Durable Medical Equipment once every three plan years.

At UnitedHealthcare's discretion, replacements are covered for damage beyond repair with normal wear and tear, when repair costs exceed new purchase price, or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Repairs, including the replacement of essential accessories, such as hoses, tubes, mouth pieces, etc., for necessary DME are only covered when required to make the item/device serviceable and the estimated repair expense does not exceed the cost of purchasing or renting another item/device. Requests for repairs may be made at any time and are not subject to the three year timeline for replacement.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support if the retail purchase cost or cumulative rental cost of a single item will exceed \$1,000. To receive Network Benefits, you must purchase or rent the DME from the vendor Personal Health Support identifies or purchase it directly from the prescribing network physician. If authorization from Personal Health Support is not obtained, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

Emergency Health Services - Outpatient

The Plan's Emergency services Benefit pays for outpatient treatment at a Hospital or Alternate Facility when required to stabilize a patient or initiate treatment.

Network Benefits will be paid for an Emergency admission to a non-Network Hospital as long as Personal Health Support is notified within one business day of the admission or on the same day of admission if reasonably possible after you are admitted to a non-Network Hospital. If you continue your stay in a non-Network Hospital after the date your Physician determines that it is medically appropriate to transfer you to a Network Hospital, Non-Network Benefits will apply.

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support within one business day of the admission or on the same day of admission if reasonably possible if you are admitted to a Hospital as a result of an Emergency. If authorization from Personal Health Support is not obtained, Benefits for the Inpatient Hospital Stay will be reduced to 50% of Eligible Expenses not to exceed \$500.

Hearing Aids

The Plan pays Benefits for hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this section only for Covered Persons who have either of the following:

- craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or

- hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Any combination of Network Benefits and Non-Network Benefits is limited to \$4,000 per plan year. Benefits are limited to a single purchase (including repair/replacement) per hearing impaired ear every three plan years.

Home Health Care

Covered Health Services are services that a Home Health Agency provides if you need care in your home due to the nature of your condition. Services must be:

- ordered by a Physician;
- provided by or supervised by a registered nurse in your home, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse;
- not considered Custodial Care, as defined in Section 14, *Glossary*; and
- provided on a part-time, Intermittent Care schedule when Skilled Care is required. Refer to Section 14, *Glossary* for the definition of Skilled Care.

Personal Health Support will decide if Skilled Care is needed by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Any combination of Network Benefits and Non-Network Benefits is limited to 100 visits per plan year. One visit equals four hours of Skilled Care services. This visit limit does not include any service which is billed only for the administration of intravenous infusion.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support five business days before receiving services or as soon as reasonably possible. If authorization from Personal Health Support is not obtained, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

Hospice Care

Hospice care is an integrated program recommended by a Physician which provides comfort and support services for the terminally ill. Hospice care can be provided on an inpatient or outpatient basis and includes physical, psychological, social, spiritual and respite care for the terminally ill person, and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available only when hospice care is received from a licensed hospice agency, which can include a Hospital.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support five business days before receiving services. If authorization from Personal Health Support is not obtained, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

Hospital - Inpatient Stay

Hospital Benefits are available for:

- non-Physician services and supplies received during an Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians.

The Plan will pay the difference in cost between a Semi-private Room and a private room only if a private room is necessary according to generally accepted medical practice.

Benefits for an Inpatient Stay in a Hospital are available only when the Inpatient Stay is necessary to prevent, diagnose or treat a Sickness or Injury. Benefits for other Hospital-based Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Benefits for Emergency admissions and admissions of less than 24 hours are described under *Emergency Health Services* and *Surgery - Outpatient, Scopic Procedures - Diagnostic and Therapeutic*, and *Therapeutic Treatments - Outpatient*, respectively.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support as follows:

- for elective admissions: five business days before admission or as soon as reasonably possible;
- for Emergency admissions (also termed non-elective admissions): as soon as is reasonably possible.

If authorization from Personal Health Support is not obtained, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

Kidney Resource Services (KRS)

The Plan pays Benefits for Comprehensive Kidney Solution (CKS) that covers both chronic kidney disease and End Stage Renal Disease (ESRD) provided by Designated Facilities participating in the Kidney Resource Services (KRS) program. Designated Facility is defined in Section 14, *Glossary*.

In order to receive Benefits under this program, KRS must provide the proper notification to the Network provider performing the services. This is true even if you self refer to a Network provider participating in the program. Notification is required:

- prior to vascular access placement for dialysis; and
- prior to any ESRD services.

You or a covered Dependent may:

- be referred to KRS by Personal Health Support; or

- call KRS toll-free at (888) 936-7246 and select the KRS prompt.

To receive Benefits related to ESRD and chronic kidney disease, you are not required to visit a Designated Facility. If you receive services from a facility that is not a Designated Facility, the Plan pays Benefits as described under:

- *Physician's Office Services - Sickness and Injury;*
- *Physician Fees for Surgical and Medical Services;*
- *Scopic Procedures - Outpatient Diagnostic and Therapeutic;*
- *Therapeutic Treatments - Outpatient;*
- *Hospital - Inpatient Stay; and*
- *Surgery - Outpatient.*

To receive Benefits under the KRS program, you must contact KRS prior to obtaining Covered Health Services. The Plan will only pay Benefits under the KRS program if KRS provides the proper notification to the Designated Facility provider performing the services (even if you self refer to a provider in that Network).

Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility include:

- lab and radiology/x-ray; and
- mammography.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*. Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services* in this section. CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient* in this section.

Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, nuclear medicine, and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for radiologists, anesthesiologists and pathologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an outpatient or inpatient basis:

diagnostic evaluations and assessment;

treatment planning;

referral services;

medication management;

individual, family, therapeutic group and provider based case management services; and

crisis intervention.

Benefits include the following services provided on an inpatient basis:

Partial Hospitalization/Day Treatment; and

services at a Residential Treatment Facility.

Benefits include the following services on an outpatient basis:

Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services.

benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Mental Health Services

Mental Health Services include those received on an inpatient or outpatient basis in a Hospital and an Alternate Facility or in a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental

Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember for Non-Network Benefits, you must obtain prior authorization from the MH/SUD Administrator to receive these Benefits. Please refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card. Without authorization, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

Neurobiological Disorders—Mental Health Services for Autism Spectrum Disorders

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorders that are both of the following:

provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and

focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following services provided on either an outpatient or inpatient basis:

diagnostic evaluations and assessment;

treatment planning;

referral services;

medication management;

individual, family, therapeutic group and provider based case management services; and

crisis intervention.

Benefits include the following services provided on an inpatient basis:

Partial Hospitalization/Day Treatment; and

services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Neurobiological Disorders –Autism Spectrum Disorder Services

The Plan pays Benefits for psychiatric services for Autism Spectrum Disorder (otherwise known as neurodevelopmental disorders) that are both of the following:

- provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider; and
- focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.

These Benefits describe only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories as described in this section.

Benefits include the following services provided on either an outpatient or inpatient basis:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;
- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Please remember for Non-Network Benefits, you must obtain prior authorization from the MH/SUD Administrator to receive these Benefits. Please refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card. Without authorization, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- pouches, face plates and belts;
- irrigation sleeves, bags and ostomy irrigation catheters; and
- skin barriers.

Pharmaceutical Products - Outpatient

The Plan pays for Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home. Examples of what would be included under this category are antibiotic injections in the Physician's office or inhaled medication in an Urgent Care Center for treatment of an asthma attack.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

Physician Fees for Surgical and Medical Services

The Plan pays Physician fees for surgical procedures and other medical care received from a Physician in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility, Alternate Facility, or for Physician house calls.

Physician's Office Services - Sickness and Injury

Benefits are paid by the Plan for Covered Health Services received in a Physician's office for the evaluation and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital. Benefits under this section include allergy injections and hearing exams in case of Injury or Sickness.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is determined to be Medically Necessary following genetic counseling when ordered by the Physician and authorized in advance by UnitedHealthcare.

Benefits for preventive services are described under *Preventive Care Services* in this section.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support for Genetic Testing – BRCA. If authorization from Personal Health Support is not obtained, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

Please Note

Your Physician does not have a copy of your SPD, and is not responsible for knowing or communicating your Benefits.

Pregnancy - Maternity Services

Benefits for Pregnancy will be paid at the same level as Benefits for any other condition, Sickness or Injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The Plan will pay Benefits for an Inpatient Stay of at least:

- 48 hours for the mother and newborn child following a vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

These are federally mandated requirements under the Newborns' and Mothers' Health Protection Act of 1996 which apply to this Plan. The Hospital or other provider is not required to get authorization for the time periods stated above. Authorizations are required for longer lengths of stay. If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum timeframes.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support as soon as reasonably possible if the Inpatient Stay for the mother and/or the newborn will be longer than the timeframes indicated above. If authorization from Personal Health Support is not obtained, Benefits for the extended stay will be reduced to 50% of Eligible Expenses not to exceed \$500.

Healthy moms and babies

The Plan provides a special prenatal program to help during Pregnancy. Participation is voluntary and free of charge. See Section 7, *Resources to Help you Stay Healthy*, for details.

Preventive Care Services

The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital. Preventive care services encompass

medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care Benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Benefits for breast pumps also include the cost of purchasing one breast pump per Pregnancy in conjunction with childbirth. These Benefits are described under Section 5, *Plan Highlights*, under *Covered Health Services*.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. UnitedHealthcare will determine the following:

- Which pump is the most cost effective;
- Whether the pump should be purchased or rented;
- Duration of a rental;
- Timing of an acquisition.

Benefits are only available if breast pumps are obtained from a DME provider or Physician.

In addition to the services listed above, this preventive care benefit includes certain:

- routine lab tests;
- diagnostic consults to prevent disease and detect abnormalities;
- diagnostic radiology and nuclear imaging procedures to screen for abnormalities;
- breast cancer screening and genetic testing; and
- tests to support cardiovascular health.

These additional services are paid under the preventive care benefit when billed by your provider with a wellness diagnosis. Call the number on the back of your ID card for additional information regarding coverage available for specific services.

For questions about your preventive care Benefits under this Plan call the number on the back of your ID card.

Prosthetic Devices

Benefits are paid by the Plan for prosthetic devices and appliances that replace a limb or body part, or help an impaired limb or body part work. Examples include, but are not limited to:

- artificial arms, legs, feet and hands;
- artificial face, eyes, ears and nose; and
- breast prosthesis following mastectomy as required by the Women's Health and Cancer Rights Act of 1998, including mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices and do not include any device that is fully implanted into the body.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the most Cost-Effective prosthetic device. The device must be ordered or provided either by a Physician, or under a Physician's direction. If you purchase a prosthetic device that exceeds these minimum specifications, the Plan may pay only the amount that it would have paid for the prosthetic that meets the minimum specifications, and you may be responsible for paying any difference in cost.

Benefits are provided for the replacement of a type of prosthetic device once every three plan years.

At UnitedHealthcare's discretion, prosthetic devices may be covered for damage beyond repair with normal wear and tear, when repair costs are less than the cost of replacement or when a change in the Covered Person's medical condition occurs sooner than the three year timeframe. Replacement of artificial limbs or any part of such devices may be covered when the condition of the device or part requires repairs that cost more than the cost of a replacement device or part.

Note: Prosthetic devices are different from DME - see *Durable Medical Equipment (DME)* in this section.

Reconstructive Procedures

Reconstructive Procedures are services performed when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function for an organ or body part. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not a changed or improved physical appearance.

Improving or restoring physiologic function means that the organ or body part is made to work better. An example of a Reconstructive Procedure is surgery on the inside of the nose so that a person's breathing can be improved or restored.

Benefits for Reconstructive Procedures include breast reconstruction following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Replacement of an existing breast implant is covered by the Plan if the initial breast implant followed mastectomy. Other services required by the Women's Health and Cancer Rights Act of 1998, including breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact UnitedHealthcare at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

There may be times when the primary purpose of a procedure is to make a body part work better. However, in other situations, the purpose of the same procedure is to improve the appearance of a body part. Cosmetic procedures are excluded from coverage. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. A good example is upper eyelid surgery. At times, this procedure will be done to improve vision, which is considered a Reconstructive Procedure. In other cases, improvement in appearance is the primary intended purpose, which is considered a Cosmetic Procedure. This Plan does not provide Benefits for Cosmetic Procedures, as defined in Section 14, *Glossary*.

The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please remember that you must obtain prior authorization from Personal Health Support five business days before undergoing a Reconstructive Procedure. When you obtain prior authorization, Personal Health Support can determine whether the service is considered reconstructive or cosmetic. Cosmetic Procedures are always excluded from coverage. In addition, for Non-Network Benefits you must contact Personal Health Support 24 hours before admission for an Inpatient Stay.

Rehabilitation Services - Outpatient Therapy and Manipulative Treatment

The Plan provides short-term outpatient rehabilitation services for the following types of therapy:

- physical therapy;
- occupational therapy;
- Manipulative Treatment;
- speech therapy;
- post-cochlear implant aural therapy;
- cognitive rehabilitation therapy following a post-traumatic brain Injury or cerebral vascular accident;
- pulmonary rehabilitation; and

- cardiac rehabilitation.

For all rehabilitation services, a licensed therapy provider, under the direction of a Physician (when required by state law), must perform the services. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

The Plan will pay Benefits for speech therapy only when the speech impediment or dysfunction results from Injury, Sickness, stroke, cancer, Autism Spectrum Disorders or a Congenital Anomaly, or is needed following the placement of a cochlear implant.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

Habilitative Services

Benefits are provided for habilitative services provided on an outpatient basis for Covered Persons with a congenital, genetic, or early acquired disorder when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service. When the Covered Person reaches his/her maximum level of improvement or does not demonstrate continued progress under a treatment plan, a service that was previously habilitative is no longer habilitative.

The Plan may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow the Plan to substantiate that initial or continued medical treatment is needed and that the Covered Person's condition is clinically improving as a result of the habilitative service. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this benefit, the following definitions apply:

- "Habilitative services" means occupational therapy, physical therapy and speech therapy prescribed by the Covered Person's treating Physician pursuant to a treatment plan to develop a function not currently present as a result of a congenital, genetic, or early acquired disorder.
- A "congenital or genetic disorder" includes, but is not limited to, hereditary disorders.
- An "early acquired disorder" refers to a disorder resulting from Sickness, Injury, trauma or some other event or condition suffered by a Covered Person prior to that Covered Person developing functional life skills such as, but not limited to, walking, talking, or self-help skills.

Other than as described under Habilitative Services above, please note that the Plan will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorders.

Benefits are limited to:

- 30 visits per plan year for physical therapy;
- 30 visits per plan year for occupational therapy;
- 30 visits per plan year for speech therapy;
- 20 visits per plan year for cognitive rehabilitation therapy;
- 20 visits per plan year for Manipulative Treatment;
- 30 visits per plan year for post-cochlear implant aural therapy.
- 30 visits per plan year for pulmonary rehabilitation therapy; and
- 36 visits per plan year for cardiac rehabilitation therapy.

These visit limits apply to Network Benefits and Non-Network Benefits combined.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support five business days before receiving Manipulative Treatment or as soon as reasonably possible. If authorization from Personal Health Support is not obtained, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

Scopic Procedures - Outpatient Diagnostic and Therapeutic

The Plan pays for diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy, and endoscopy.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services - Sickness and Injury* in this section. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy.

When these services are performed for preventive screening purposes, Benefits are described in this section under *Preventive Care Services*.

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Facility services for an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility are covered by the Plan. Benefits include:

- non-Physician services and supplies received during the Inpatient Stay;
- room and board in a Semi-private Room (a room with two or more beds); and
- Physician services for radiologists, anesthesiologists and pathologists.

Benefits are available when skilled nursing and/or Inpatient Rehabilitation Facility services are needed on a daily basis. Benefits are also available in a Skilled Nursing Facility or Inpatient Rehabilitation Facility for treatment of a Sickness or Injury that would have otherwise required an Inpatient Stay in a Hospital.

Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

UnitedHealthcare will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits are available only if:

- the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a Cost Effective alternative to an Inpatient Stay in a Hospital; and
- you will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching, and skilled rehabilitation services when:

- it is delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient;
- it is ordered by a Physician;

- it is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair; and
- it requires clinical training in order to be delivered safely and effectively.

You are expected to improve to a predictable level of recovery. Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

Note: The Plan does not pay Benefits for Custodial Care or domiciliary care, even if ordered by a Physician, as defined in Section 14, *Glossary*.

Any combination of Network Benefits and Non-Network Benefits is limited to 100 days per plan year.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support as follows:

- for elective admissions: five business days before admission;
- for Emergency admissions (also termed non-elective admissions): as soon as is reasonably possible.

If authorization from Personal Health Support is not obtained, Benefits for the extended stay will be reduced to 50% of Eligible Expenses not to exceed \$500.

In addition, for Non-Network Benefits you must contact Personal Health Support 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Substance Use Disorder Services

Substance Use Disorder Services include those received on an inpatient basis in a Hospital or an Alternate Facility and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

diagnostic evaluations and assessment;

treatment planning;

referral services;

medication management;

individual, family, therapeutic group and provider based case management;

crisis intervention; and

detoxification (sub-acute/non-medical).

Benefits include the following services provided on an inpatient basis:

Partial Hospitalization/Day Treatment; and

services at a Residential Treatment Facility.

Benefits include the following services provided on an outpatient basis:

Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Substance Use Disorder Services

Substance Use Disorder Services (also known as substance-related and addictive disorders services) include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility, or in a provider's office.

Benefits include the following services:

- diagnostic evaluations and assessment;
- treatment planning;
- treatment and/or procedures;
- referral services;
- medication management;
- individual, family, therapeutic group and provider-based case management services;
- crisis intervention;

- Partial Hospitalization/Day Treatment;
- services at a Residential Treatment Facility; and
- Intensive Outpatient Treatment.

The Mental Health/Substance Use Disorder Administrator determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

You are encouraged to contact the Mental Health/Substance Use Disorder Administrator for referrals to providers and coordination of care.

Special Substance Use Disorder Programs and Services

Special programs and services that are contracted under the Mental Health/Substance Use Disorder Administrator may become available to you as part of your Substance Use Disorder Services Benefit. The Substance Use Disorder Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance use disorder which may not otherwise be covered under this Plan. You must be referred to such programs through the Mental Health/Substance Use Disorder Administrator, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such program or service is at the discretion of the Covered Person and is not mandatory.

Please remember for Non-Network Benefits, you must obtain prior authorization from the MH/SUD Administrator to receive these Benefits. Please refer to Section 4, *Personal Health Support* for the specific services that require notification. Please call the phone number that appears on your ID card. Without notification, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

Surgery - Outpatient

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support for diagnostic catheterization, electrophysiology implant and sleep apnea surgeries five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If authorization from Personal Health Support is not obtained, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

Therapeutic Treatments - Outpatient

The Plan pays Benefits for therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment; and
- there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described in this section under *Physician Fees for Surgical and Medical Services*.

When these services are performed in a Physician's office, Benefits are described under *Physician's Office Services*.

Please remember for Non-Network Benefits, you must obtain prior authorization from Personal Health Support five business days before scheduled dialysis services are received and for intensity modulated radiation therapy and MR-guided focused ultrasounds or, for non-scheduled services, within one business day or as soon as is reasonably possible. If authorization from Personal Health Support is not obtained, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

Transplantation Services

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a provider. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart;
- heart/lung;
- lung;
- kidney;
- kidney/pancreas;
- liver;
- liver/kidney;
- liver/intestinal;
- pancreas;
- intestinal; and
- bone marrow (either from you or from a compatible donor) and peripheral stem cell transplants, with or without high dose chemotherapy. Not all bone marrow transplants meet the definition of a Covered Health Service.

Benefits are also available for cornea transplants. You are not required to obtain prior authorization from United Resource Networks or Personal Health Support of a cornea transplant nor is the cornea transplant required to be performed at a Designated Facility.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under the Plan.

The Plan has specific guidelines regarding Benefits for transplant services. Contact United Resource Networks at (888) 936-7246 or Personal Health Support at the telephone number on your ID card for information about these guidelines.

Please remember for Non-Network Benefits, you must obtain prior authorization from United Resource Networks or Personal Health Support as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If authorization from United Resource Networks or Personal Health Support is not obtained, Benefits will be reduced to 50% of Eligible Expenses not to exceed \$500.

In addition, for Non-Network Benefits you must contact the Personal Health Support 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions (including Emergency admissions).

Travel and Lodging

United Resource Networks or Personal Health Support will assist the patient and family with travel and lodging arrangements related to transplantation services.

For travel and lodging services to be covered, the patient must be receiving services at a Designated Facility through United Resource Networks.

The Plan covers expenses for travel and lodging for the patient, provided he or she is not covered by Medicare, and a companion as follows:

- transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the procedure or necessary post-discharge follow-up;
- Eligible Expenses for lodging for the patient (while not a Hospital inpatient) and one companion. Benefits are paid at a per diem (per day) rate of up to \$50 per day for the patient or up to \$100 per day for the patient plus one companion; or
- if the patient is an enrolled Dependent minor child, the transportation expenses of two companions will be covered and lodging expenses will be reimbursed at a per diem rate up to \$100 per day.

Travel and lodging expenses are only available if the recipient lives more than 50 miles from the Designated Facility. UnitedHealthcare must receive valid receipts for such charges before you will be reimbursed. Examples of travel expenses may include:

- airfare at coach rate;
- taxi or ground transportation; or
- mileage reimbursement at the IRS rate for the most direct route between the patient's home and the Designated Facility.

A combined overall maximum Benefit of \$10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all transplant procedures during the entire period that person is covered under this Plan.

Support in the event of serious illness

If you or a covered family member has cancer or needs an organ or bone marrow transplant, UnitedHealthcare can put you in touch with quality treatment centers around the country.

Urgent Care Center Services

The Plan provides Benefits for services, including professional services, received at an Urgent Care Center, as defined in Section 14, *Glossary*. When Urgent Care services are provided in a Physician's office, the Plan pays Benefits as described under *Physician's Office Services - Sickness and Injury* earlier in this section.

Vision Examinations

The Plan pays Benefits for:

- vision screenings, which could be performed as part of an annual physical examination in a provider's office (vision screenings do not include refractive examinations to detect vision impairment); and
- one routine vision exam, including refraction, to detect vision impairment by a provider in the provider's office every plan year.

SECTION 7 - RESOURCES TO HELP YOU STAY HEALTHY

What this section includes:

Health and well-being resources available to you, including:

- Consumer Solutions and Self-Service Tools;
- Disease and Condition Management Services; and
- Wellness Programs.

Taft Stettinius & Hollister LLP believes in giving you the tools you need to be an educated health care consumer. To that end, Taft Stettinius & Hollister LLP has made available several convenient educational and support services, accessible by phone and the Internet, which can help you to:

- take care of yourself and your family members;
- manage a chronic health condition; and
- navigate the complexities of the health care system.

NOTE:

Information obtained through the services identified in this section is based on current medical literature and on Physician review. It is not intended to replace the advice of a doctor. The information is intended to help you make better health care decisions and take a greater responsibility for your own health. UnitedHealthcare and Taft Stettinius & Hollister LLP are not responsible for the results of your decisions from the use of the information, including, but not limited to, your choosing to seek or not to seek professional medical care, or your choosing or not choosing specific treatment based on the text.

Consumer Solutions and Self-Service Tools

Health Assessment

You and your Spouse are invited to learn more about your health and wellness at **www.myuhc.com** and are encouraged to participate in the online health assessment. The health assessment is an interactive questionnaire designed to help you identify your healthy habits as well as potential health risks.

Your health assessment is kept confidential. Completing the assessment will not impact your Benefits or eligibility for Benefits in any way.

To find the health assessment, log in to **www.myuhc.com**. After logging in, access your personalized *Health & Wellness* page and click the *Health Assessment* link. If you need any assistance with the online assessment, please call the number on the back of your ID card.

Health Improvement Plan

You can start a Health Improvement Plan at any time. This plan is created just for you and includes information and interactive tools, plus online health coaching recommendations based on your profile.

Online coaching is available for:

- nutrition;
- exercise;
- weight management;
- stress;
- smoking cessation;
- diabetes; and
- heart health.

To help keep you on track with your Health Improvement Plan and online coaching, you'll also receive personalized messages and reminders – Taft Stettinius & Hollister LLP's way of helping you meet your health and wellness goals.

NurseLineSM

NurseLineSM is a toll-free telephone service that puts you in immediate contact with an experienced registered nurse any time, 24 hours a day, seven days a week. Nurses can provide health information for routine or urgent health concerns. When you call, a registered nurse may refer you to any additional resources that Taft Stettinius & Hollister LLP has available to help you improve your health and well-being or manage a chronic condition. Call any time when you want to learn more about:

- a recent diagnosis;
- a minor Sickness or Injury;
- men's, women's, and children's wellness;
- how to take Prescription Drugs safely;
- self-care tips and treatment options;
- healthy living habits; or
- any other health related topic.

NurseLineSM gives you another convenient way to access health information. By calling the same toll-free number, you can listen to one of the Health Information Library's over 1,100 recorded messages, with over half in Spanish.

NurseLineSM is available to you at no cost. To use this convenient service, simply call the toll-free number on the back of your ID card.

Note: If you have a medical emergency, call 911 instead of calling NurseLineSM.

Your child is running a fever and it's 1:00 AM. What do you do?

Call NurseLineSM toll-free, any time, 24 hours a day, seven days a week. You can count on NurseLineSM to help answer your health questions.

With NurseLineSM, you also have access to nurses online. To use this service, log onto **www.myuhc.com** and click "Live Nurse Chat" in the top menu bar. You'll instantly be connected with a registered nurse who can answer your general health questions any time, 24 hours a day, seven days a week. You can also request an e-mailed transcript of the conversation to use as a reference.

Note: If you have a medical emergency, call 911 instead of logging onto **www.myuhc.com**.

Reminder Programs

To help you stay healthy, UnitedHealthcare may send you and your covered Dependents reminders to schedule recommended screening exams. Examples of reminders include:

- mammograms for women between the ages of 40 and 68;
- pediatric and adolescent immunizations;
- cervical cancer screenings for women between the ages of 20 and 64;
- comprehensive screenings for individuals with diabetes; and
- influenza/pneumonia immunizations for enrollees age 65 and older.

There is no need to enroll in this program. You will receive a reminder automatically if you have not had a recommended screening exam.

Treatment Decision Support

In order to help you make informed decisions about your health care, UnitedHealthcare has a program called Treatment Decision Support. This program targets specific conditions as well as the treatments and procedures for those conditions.

This program offers:

- access to accurate, objective and relevant health care information;
- coaching by a nurse through decisions in your treatment and care;
- expectations of treatment; and
- information on high quality providers and programs.

Conditions for which this program is available include:

- back pain;
- knee & hip replacement;
- prostate disease;
- prostate cancer;
- benign uterine conditions;
- breast cancer; and

- coronary disease.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

UnitedHealth PremiumSM Program

UnitedHealthcare designates Network Physicians and facilities as UnitedHealth PremiumSM Program Physicians or facilities for certain medical conditions. Physicians and facilities are evaluated on two levels - quality and efficiency of care. The UnitedHealth PremiumSM Program was designed to:

- help you make informed decisions on where to receive care;
- provide you with decision support resources; and
- give you access to Physicians and facilities across areas of medicine that have met UnitedHealthcare's quality and efficiency criteria.

For details on the UnitedHealth PremiumSM Program including how to locate a UnitedHealth PremiumSM Physician or facility, log onto **www.myuhc.com** or call the toll-free number on your ID card.

www.myuhc.com

UnitedHealthcare's member website, **www.myuhc.com**, provides information at your fingertips anywhere and anytime you have access to the Internet. **www.myuhc.com** opens the door to a wealth of health information and convenient self-service tools to meet your needs.

With **www.myuhc.com** you can:

- receive personalized messages that are posted to your own website;
- research a health condition and treatment options to get ready for a discussion with your Physician;
- search for Network providers available in your Plan through the online provider directory;
- access all of the content and wellness topics from NurseLine including Live Nurse Chat 24 hours a day, seven days a week;
- complete a health risk assessment to identify health habits you can improve, learn about healthy lifestyle techniques and access health improvement resources;
- use the treatment cost estimator to obtain an estimate of the costs of various procedures in your area; and
- use the Hospital comparison tool to compare Hospitals in your area on various patient safety and quality measures.

Registering on www.myuhc.com

If you have not already registered as a **www.myuhc.com** subscriber, simply go to **www.myuhc.com** and click on "Register Now." Have your UnitedHealthcare ID card handy. The enrollment process is quick and easy.

Visit **www.myuhc.com** and:

- make real-time inquiries into the status and history of your claims;
- view eligibility and Plan Benefit information, including Annual Deductibles;
- view and print all of your Explanation of Benefits (EOBs) online; and
- order a new or replacement ID card or, print a temporary ID card.

Want to learn more about a condition or treatment?

Log on to **www.myuhc.com** and research health topics that are of interest to you. Learn about a specific condition, what the symptoms are, how it is diagnosed, how common it is, and what to ask your Physician.

Disease and Condition Management Services

Diabetes Prevention and Control

UnitedHealthcare provides two programs that identify, assess, and support members over the age of 18 living with diabetes or pre-diabetes. The program is designed to support members in preventing pre-diabetics from progressing to diabetes and assist members living with diabetes in controlling their condition and from developing complications.

The Diabetes Prevention Program (DPP) is available for members living with pre-diabetes and offers a 16 session lifestyle intervention that addresses diet, activity and behavior modification. The goal of this program is to slow and/or prevent the development of Type 2 diabetes through lifestyle management and weight loss and is available at local YMCAs.

The Diabetes Control Program (DCP) is available to members living with diabetes and offers face-to-face consultations with trained local pharmacists who will review diabetes history and medication, provide diabetes management education materials and assist individuals living with diabetes with managing their condition. The goal of this program is to reduce the risk of serious health complications through medication management and ongoing monitoring for complications.

Participation is completely voluntary and without extra charge. There are no Copays, Coinsurance or Deductibles that need to be met when services are received as part of the DPP or DCP programs. If you think you may be eligible to participate or would like additional information regarding the programs, please call the DPCA call center directly at (888) 688-4019.

Disease Management Services

If you have been diagnosed with or are at risk for developing certain chronic medical conditions you may be eligible to participate in a disease management program at no cost to you. The heart failure, coronary artery disease, diabetes and asthma programs are designed to

support you. This means that you will receive free educational information through the mail, and may even be called by a registered nurse who is a specialist in your specific medical condition. This nurse will be a resource to advise and help you manage your condition.

These programs offer:

- educational materials mailed to your home that provide guidance on managing your specific chronic medical condition. This may include information on symptoms, warning signs, self-management techniques, recommended exams and medications;
- access to educational and self-management resources on a consumer website;
- an opportunity for the disease management nurse to work with your Physician to ensure that you are receiving the appropriate care; and
- toll-free access to and one-on-one support from a registered nurse who specializes in your condition. Examples of support topics include:
 - education about the specific disease and condition,
 - medication management and compliance,
 - reinforcement of on-line behavior modification program goals,
 - preparation and support for upcoming Physician visits,
 - review of psychosocial services and community resources,
 - caregiver status and in-home safety,
 - use of mail-order pharmacy and Network providers.

Participation is completely voluntary and without extra charge. If you think you may be eligible to participate or would like additional information regarding the program, please contact the number on the back of your ID card.

HealtheNotesSM

UnitedHealthcare provides a service called HealtheNotes to help educate members and make suggestions regarding your medical care. HealtheNotes provides you and your Physician with suggestions regarding preventive care, testing or medications, potential interactions with medications you have been prescribed, and certain treatments. In addition, your HealtheNotes report may include health tips and other wellness information.

UnitedHealthcare makes these suggestions through a software program that provides retrospective, claims-based identification of medical care. Through this process patients are identified whose care may benefit from suggestions using the established standards of evidence based medicine as described in Section 14, *Glossary* under the definition of Covered Health Services.

If your Physician identifies any concerns after reviewing his or her HealtheNotes report, he or she may contact you if he or she believes it to be appropriate. In addition, you may use the information in your report to engage your Physician in discussions regarding your health and the identified suggestions. Any decisions regarding your care, though, are always between you and your Physician.

If you have questions or would like additional information about this service, please call the number on the back of your ID card.

Wellness Programs

Healthy Pregnancy Program

If you are pregnant and enrolled in the medical Plan, you can get valuable educational information and advice by calling the toll-free number on your ID card. This program offers:

- pregnancy consultation to identify special needs;
- written and on-line educational materials and resources;
- 24-hour toll-free access to experienced maternity nurses;
- a phone call from a care coordinator during your Pregnancy, to see how things are going; and
- a phone call from a care coordinator approximately four weeks postpartum to give you information on infant care, feeding, nutrition, immunizations and more.

Participation is completely voluntary and without extra charge. To take full advantage of the program, you are encouraged to enroll within the first 12 weeks of Pregnancy. You can enroll any time, up to your 34th week. To enroll, call the toll-free number on the back of your ID card.

As a program participant, you can call any time, 24 hours a day, seven days a week, with any questions or concerns you might have.

SECTION 8 - EXCLUSIONS: WHAT THE MEDICAL PLAN WILL NOT COVER

What this section includes:

- Services, supplies and treatments that are not Covered Health Services, except as may be specifically provided for in Section 6, *Additional Coverage Details*.

The Plan does not pay Benefits for the following services, treatments or supplies even if they are recommended or prescribed by a provider or are the only available treatment for your condition.

When Benefits are limited within any of the Covered Health Services categories described in Section 6, *Additional Coverage Details*, those limits are stated in the corresponding Covered Health Service category in Section 5, *Plan Highlights*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in Section 5, *Plan Highlights*. Please review all limits carefully, as the Plan will not pay Benefits for any of the services, treatments, items or supplies that exceed these benefit limits.

Please note that in listing services or examples, when the SPD says "this includes," or "including but not limited to", it is not UnitedHealthcare's intent to limit the description to that specific list. When the Plan does intend to limit a list of services or examples, the SPD specifically states that the list "is limited to."

Alternative Treatments

1. acupressure;
2. acupuncture;
3. aromatherapy;
4. hypnotism;
5. massage therapy;
6. Rolfing (holistic tissue massage); and
7. art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institutes of Health. This exclusion does not apply to Manipulative Treatment and non-manipulative osteopathic care for which Benefits are provided as described in Section 6, *Additional Coverage Details*.

Dental

1. dental care, except as identified under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*;

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. diagnosis or treatment of or related to the teeth, jawbones or gums. Examples include:

- extractions (including wisdom teeth);
- restoration and replacement of teeth;
- medical or surgical treatments of dental conditions; and
- services to improve dental clinical outcomes;

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

3. dental implants, bone grafts, and other implant-related procedures;

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in Section 6, *Additional Coverage Details*.

4. dental braces (orthodontics);

5. dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia; and

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under the Plan, as identified in Section 6, *Additional Coverage Details*.

6. treatment of congenitally missing (when the cells responsible for the formation of the tooth are absent from birth), malpositioned or supernumerary (extra) teeth, even if part of a Congenital Anomaly such as cleft lip or cleft palate.

Devices, Appliances and Prosthetics

1. devices used specifically as safety items or to affect performance in sports-related activities;
2. orthotic appliances and devices that straighten or re-shape a body part, except as described under *Durable Medical Equipment (DME)* in Section 6, *Additional Coverage Details*;

Examples of excluded orthotic appliances and devices include but are not limited to, foot orthotics or any orthotic braces available over-the-counter. This exclusion does not

include diabetic footwear which may be covered for a Covered Person with diabetic foot disease.

3. cranial banding;
4. the following items are excluded, even if prescribed by a Physician:
 - blood pressure cuff/monitor;
 - enuresis alarm;
 - non-wearable external defibrillator;
 - trusses;
 - ultrasonic nebulizers;
5. the repair and replacement of prosthetic devices when damaged due to misuse, malicious breakage or gross neglect;
6. the replacement of lost or stolen prosthetic devices;
7. devices and computers to assist in communication and speech except for speech aid devices and tracheo-esophageal voice devices for which Benefits are provided as described under *Durable Medical Equipment* in Section 6, *Additional Coverage Details*;
8. oral appliances for snoring.

Drugs

The exclusions listed below apply to the medical portion of the Plan only. Prescription Drug coverage is excluded under the medical plan because it is a separate benefit. Coverage may be available under the Prescription Drug portion of the Plan. See Section 15, *Prescription Drugs*, for coverage details and exclusions.

1. Prescription Drugs for outpatient use that are filled by a prescription order or refill;
2. self-injectable medications. This exclusion does not apply to medications which, due to their characteristics, (as determined by UnitedHealthcare), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting;
3. growth hormone therapy;
4. non-injectable medications given in a Physician's office except as required in an Emergency and consumed in the Physician's office; and
5. over the counter drugs and treatments.

Experimental or Investigational or Unproven Services

1. Experimental or Investigational Services or Unproven Services, unless the Plan has agreed to cover them as defined in Section 14, *Glossary*.

This exclusion applies even if Experimental or Investigational Services or Unproven Services, treatments, devices or pharmacological regimens are the only available treatment options for your condition.

This exclusion does not apply to Covered Health Services provided during a Clinical Trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.

Foot Care

1. routine foot care, except when needed for severe systemic disease or preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*. Routine foot care services that are not covered include:

- cutting or removal of corns and calluses;
- nail trimming or cutting; and
- debriding (removal of dead skin or underlying tissue);

2. hygienic and preventive maintenance foot care. Examples include:

- cleaning and soaking the feet;
- applying skin creams in order to maintain skin tone; and other services that are performed when there is not a localized Sickness, Injury or symptom involving the foot;

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

3. treatment of flat feet;
4. treatment of subluxation of the foot;
5. shoe inserts;
6. arch supports;
7. shoes (standard or custom), lifts and wedges; and
8. shoe orthotics.

Medical Supplies and Equipment

1. prescribed or non-prescribed medical and disposable supplies. Examples of supplies that are not covered include, but are not limited to:

- compression stockings, ace bandages, diabetic strips, and syringes; and
- urinary catheters.

This exclusion does not apply to:

- ostomy bags and related supplies for which Benefits are provided as described under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.
 - disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*; or
 - diabetic supplies for which Benefits are provided as described under *Diabetes Services* in Section 6, *Additional Coverage Details*.
2. tubings, nasal cannulas, connectors and masks except when used with Durable Medical Equipment;
 3. the repair and replacement of Durable Medical Equipment when damaged due to misuse, malicious breakage or gross neglect;
 4. the replacement of lost or stolen Durable Medical Equipment; and
 5. deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover or other items that are not specifically identified under *Ostomy Supplies* in Section 6, *Additional Coverage Details*.

Mental Health/Substance Use Disorder

Exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders*, *Mental Health Services for Autism Spectrum Disorders* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
2. services or supplies for the diagnosis or treatment of Mental Illness, alcoholism or substance use disorders that, in the reasonable judgment of the Mental Health/Substance Use Disorder Administrator, are any of the following:
 - not consistent with generally accepted standards of medical practice for the treatment of such conditions;
 - not consistent with services backed by credible research soundly demonstrating that the services or supplies will have a measurable and beneficial health outcome, and therefore considered experimental;
 - not consistent with the Mental Health/Substance Use Disorder Administrator's level of care guidelines or best practices as modified from time to time; or

- not clinically appropriate for the patient's Mental Illness, Substance Use Disorder or condition based on generally accepted standards of medical practice and benchmarks.
- 3. Mental Health Services as treatments for V code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- 4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep disorders, sexual dysfunction disorders, feeding disorders, neurological disorders and other disorders with a known physical basis;
- 5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilias (sexual behavior that is considered deviant or abnormal);
- 6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
- 7. tuition for or services that are school based for children and adolescents under the *Individuals with Disabilities Education Act*;
- 8. learning, motor skills and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- 9. mental retardation as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
- 10. methadone treatment as maintenance, L.A.A.M. (1 Alpha Acetyl Methadol); Cyclazocine, or their equivalents for drug addiction;
- 11. intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorders; and
- 12. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Mental Health and Substance Use Disorder

In addition to all other exclusions listed in this Section 8, *Exclusions*, the exclusions listed directly below apply to services described under *Mental Health Services*, *Neurobiological Disorders - Autism Spectrum Disorder Services* and/or *Substance Use Disorder Services* in Section 6, *Additional Coverage Details*.

- 1. services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;

2. health services or supplies that do not meet the definition of a Covered Health Service – see the definition in Section 14, *Glossary*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which the Claims Administrator determines to be all of the following:
 - Medically Necessary;
 - described as a Covered Health Service in this Plan under Section 5, *Plan Highlights* and Section 6, *Additional Coverage Details*; and
 - not otherwise excluded in this Plan under this Section 8, *Exclusions*;
3. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
4. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, neurological disorders and other disorders with a known physical basis;
5. treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder;
6. educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning;
7. tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*;
8. learning, motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
9. intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
11. all unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*;
12. methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents for drug addiction;
13. intensive behavioral therapies such as applied behavioral analysis for Autism Spectrum Disorder; and
14. any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.

Nutrition

1. nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements, and other nutrition based therapy;
2. nutritional counseling for either individuals or groups; Individual and group nutritional counseling. This exclusion does not apply to nutritional counseling services that are billed as Preventive Care Services or to nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - nutritional education is required for a disease in which patient self-management is an important component of treatment; and
 - there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional;
3. food of any kind. Foods that are not covered include:
 - enteral feedings and other nutritional and electrolyte formulas, including infant formula and donor breast milk, even if they are the only source of nutrition and even if they are specifically created to treat inborn errors of metabolism such as phenylketonuria (PKU). Infant formula available over the counter is always excluded;
 - foods to control weight, treat obesity (including liquid diets), lower cholesterol or control diabetes;
 - oral vitamins and minerals;
 - meals you can order from a menu, for an additional charge, during an Inpatient Stay; and
 - other dietary and electrolyte supplements; and
4. health education classes unless offered by UnitedHealthcare or its affiliates, including but not limited to asthma, smoking cessation, and weight control classes.

Personal Care, Comfort or Convenience

1. television;
2. telephone;
3. beauty/barber service;
4. guest service;
5. supplies, equipment and similar incidentals for personal comfort. Examples include:
 - air conditioners;
 - air purifiers and filters;
 - batteries and battery chargers;
 - dehumidifiers and humidifiers;
 - ergonomically correct chairs;

- non-Hospital beds, comfort beds, motorized beds and mattresses;
- breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the Health Resources and Services Administration (HRSA) requirement;
- car seats;
- chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners;
- exercise equipment and treadmills;
- hot tubs, Jacuzzis, saunas and whirlpools;
- medical alert systems;
- music devices;
- personal computers;
- pillows;
- power-operated vehicles;
- radios;
- safety equipment;
- strollers;
- vehicle modifications such as van lifts;
- video players; and
- home modifications to accommodate a health need (including, but not limited to, ramps, swimming pools, elevators, handrails, and stair glides).

Physical Appearance

1. Cosmetic Procedures, as defined in Section 14, *Glossary*, are excluded from coverage. Examples include:
 - liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple;
 - pharmacological regimens;
 - nutritional procedures or treatments;
 - tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures);
 - hair removal or replacement by any means;
 - treatments for skin wrinkles or any treatment to improve the appearance of the skin;
 - treatment for spider veins;
 - skin abrasion procedures performed as a treatment for acne;
 - treatments for hair loss;
 - varicose vein treatment of the lower extremities, when it is considered cosmetic; and
 - replacement of an existing intact breast implant if the earlier breast implant was performed as a Cosmetic Procedure;
2. physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility, health club memberships and programs, spa treatments, and diversion or general motivation;
3. weight loss programs whether or not they are under medical supervision or for medical reasons, even if for morbid obesity;
4. wigs regardless of the reason for the hair loss; and

5. treatment of benign gynecomastia (abnormal breast enlargement in males).

Procedures and Treatments

1. biofeedback;
2. medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer);
3. rehabilitation services and Manipulative Treatment to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment;
4. speech therapy to treat stuttering, stammering, or other articulation disorders;
5. speech therapy, except when required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, a Congenital Anomaly or Autism Spectrum Disorders as identified under *Rehabilitation Services – Outpatient Therapy and Manipulative Treatment* in Section 6, *Additional Coverage Details*;
6. a procedure or surgery to remove fatty tissue such as panniculectomy, abdominoplasty, thighplasty, brachioplasty, or mastopexy;
7. excision or elimination of hanging skin on any part of the body (examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty);
8. psychosurgery (lobotomy);
9. stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. The programs usually include intensive psychological support, behavior modification techniques and medications to control cravings;
10. chelation therapy, except to treat heavy metal poisoning;
11. Manipulative Treatment to treat a condition unrelated to spinal manipulation and ancillary physiologic treatment rendered to restore/improve motion, reduce pain and improve function, such as asthma or allergies;
12. physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter;
13. sex transformation operations and related services;
14. the following treatments for obesity:

- non-surgical treatment, even if for morbid obesity; and
 - surgical treatment of obesity even if there is a diagnosis of morbid obesity;
15. medical and surgical treatment of hyperhidrosis (excessive sweating);
 16. services for the evaluation and treatment of temporomandibular joint syndrome (TMJ), when the services are considered medical or dental in nature;
 17. upper and lower jawbone surgery, orthognathic surgery and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors or cancer or obstructive sleep apnea; and
 18. breast reduction surgery except as coverage is required by the Women's Health and Cancer Rights Act of 1998 for which Benefits are described under *Reconstructive Procedures* in Section 6, *Additional Coverage Details*.

Providers

Services:

1. performed by a provider who is a family member by birth or marriage, including your Spouse, brother, sister, parent or child;
2. a provider may perform on himself or herself;
3. performed by a provider with your same legal residence;
4. ordered or delivered by a Christian Science practitioner;
5. performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license;
6. provided at a diagnostic facility (Hospital or free-standing) without a written order from a provider;
7. which are self-directed to a free-standing or Hospital-based diagnostic facility; and
8. ordered by a provider affiliated with a diagnostic facility (Hospital or free-standing), when that provider is not actively involved in your medical care:
 - prior to ordering the service; or
 - after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

1. health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment.

This exclusion does not apply to services required to treat or correct underlying causes of infertility.

2. storage and retrieval of all reproductive materials (examples include eggs, sperm, testicular tissue and ovarian tissue);
3. in vitro fertilization regardless of the reason for treatment;
4. surrogate parenting, donor eggs, donor sperm and host uterus;
5. the reversal of voluntary sterilization;
6. artificial reproductive treatments done for genetic or eugenic (selective breeding) purposes;
7. services provided by a doula (labor aide); and
8. parenting, pre-natal or birthing classes.

Services Provided under Another Plan

Services for which coverage is available:

1. under another plan, except for Eligible Expenses payable as described in Section 10, *Coordination of Benefits (COB)*;
2. under workers' compensation, no-fault automobile coverage or similar legislation if you could elect it, or could have it elected for you;
3. while on active military duty; and
4. for treatment of military service-related disabilities when you are legally entitled to other coverage, and facilities are reasonably accessible.

Transplants

1. health services for organ and tissue transplants, except as identified under *Transplantation Services* in Section 6, *Additional Coverage Details* unless UnitedHealthcare determines the transplant to be appropriate according to UnitedHealthcare's transplant guidelines;
2. mechanical or animal organ transplants, except services related to the implant or removal of a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available); and
3. donor costs for organ or tissue transplantation to another person (these costs may be payable through the recipient's benefit plan).

Travel

1. health services provided in a foreign country, unless required as Emergency Health Services; and
2. travel or transportation expenses, even if ordered by a Physician, except as identified under *Travel and Lodging* in Section 6, *Additional Coverage Details*. Additional travel

expenses related to Covered Health Services received from a Designated Facility or Designated Physician may be reimbursed at the Plan's discretion. This exclusion does not apply to ambulance transportation for which Benefits are provided as described under *Ambulance Services* in Section 6, *Additional Coverage Details*.

Types of Care

1. Custodial Care as defined in Section 14, *Glossary* or maintenance care;
2. Domiciliary Care, as defined in Section 14, *Glossary*;
3. multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain;
4. Private Duty Nursing;
5. respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under *Hospice Care* in Section 6, *Additional Coverage Details*;
6. rest cures;
7. services of personal care attendants;
8. work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Vision and Hearing

1. implantable lenses used only to correct a refractive error (such as Intacs corneal implants);
2. purchase cost and associated fitting charges for eyeglasses or contact lenses;
3. bone anchored hearing aids except when either of the following applies:
 - for Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
 - for Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

The Plan will not pay for more than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled in this Plan. In addition, repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage are not covered, other than for malfunctions;

4. eye exercise or vision therapy; and

5. surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.

All Other Exclusions

1. autopsies and other coroner services and transportation services for a corpse;
2. charges for:
 - missed appointments;
 - room or facility reservations;
 - completion of claim forms; or
 - record processing.
3. charges prohibited by federal anti-kickback or self-referral statutes;
4. diagnostic tests that are:
 - delivered in other than a Physician's office or health care facility; and
 - self-administered home diagnostic tests, including but not limited to HIV and Pregnancy tests;
5. expenses for health services and supplies:
 - that are received as a result of war or any act of war, whether declared or undeclared, while part of any armed service force of any country. This exclusion does not apply to Covered Persons who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone;
 - that are received after the date your coverage under this Plan ends, including health services for medical conditions which began before the date your coverage under the Plan ends;
 - for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Benefit Plan;
 - that exceed Eligible Expenses or any specified limitation in this SPD;
 - for which a non-Network provider waives the Annual Deductible or Coinsurance amounts;
6. foreign language and sign language services;
7. long term (more than 30 days) storage of blood, umbilical cord or other material. Examples include cryopreservation of tissue, blood and blood products;
8. health services and supplies that do not meet the definition of a Covered Health Service – see the definition in Section 14, *Glossary*. Covered Health Services are those health services including services, supplies or Prescription Drugs, which the Claims Administrator determines to be all of the following:
 - Medically Necessary;
 - described as a Covered Health Service in this Summary Plan Description; and

- not otherwise excluded in this Summary Plan Description under this Section 8, Exclusions.
9. physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments when:
- required solely for purposes of education, sports or camp, travel, career or employment, insurance, marriage or adoption; or as a result of incarceration;
 - conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in Section 6, *Additional Coverage Details*;
 - related to judicial or administrative proceedings or orders; or
 - required to obtain or maintain a license of any type.

SECTION 9 - CLAIMS PROCEDURES

What this section includes:

- How Network and non-Network claims work; and
- What to do if your claim is denied, in whole or in part.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will pay the Physician or facility directly. If a Network provider bills you for any Covered Health Service other than your Coinsurance, please contact the provider or call UnitedHealthcare at the phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

Prescription Drug Benefit Claims

If you wish to receive reimbursement for a prescription, you may submit a post-service claim as described in this section if:

- you are asked to pay the full cost of the Prescription Drug when you fill it and you believe that the Plan should have paid for it; or
- you pay a Copay and you believe that the amount of the Copay was incorrect.

If a pharmacy (retail or mail order) fails to fill a prescription that you have presented and you believe that it is a Covered Health Service, you may submit a pre-service request for Benefits as described in this section.

If Your Provider Does Not File Your Claim

You can obtain a claim form by visiting www.myuhc.com, calling the toll free number on your ID card or contacting Human Resources. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

your name and address;

the patient's name, age and relationship to the Participant;

the number as shown on your ID card;

the name, address and tax identification number of the provider of the service(s);

a diagnosis from the Physician;

the date of service;

an itemized bill from the provider that includes:

- the Current Procedural Terminology (CPT) codes;
- a description of, and the charge for, each service;
- the date the Sickness or Injury began; and
- a statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

For medical claims, the above information should be filed with UnitedHealthcare at the address on your ID card. When filing a claim for outpatient Prescription Drug Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

After UnitedHealthcare has processed your claim, you will receive payment for Benefits that the Plan allows. It is your responsibility to pay the non-Network provider the charges you incurred, including any difference between what you were billed and what the Plan paid.

UnitedHealthcare will pay Benefits to you unless:

the provider notifies UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider; or

you make a written request for the non-Network provider to be paid directly at the time you submit your claim;

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider has assigned Benefits to that third party.

When you assign your Benefits under the Plan to a non-Network provider with UnitedHealthcare's consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant that the Covered Health Services were actually provided and were medically appropriate.

To be recognized as a valid assignment of Benefits under the Plan, the assignment must reflect the Covered Person's agreement that the non-Network provider will be entitled to all the Covered Person's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning the Covered Person's Benefits, and that the Covered Person will no longer be entitled to those rights. If an assignment form

does not comply with this requirement, but directs that your benefit payment should be made directly to the provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat you, rather than the provider, as the beneficiary of your claim. If Benefits are assigned or payment to a non-Network provider is made, Taft Stettinius & Hollister LLP reserves the right to offset Benefits to be paid to the provider by any amounts that the provider owes Taft Stettinius & Hollister LLP pursuant to *Refund of Overpayments* in Section 10, *Coordination of Benefits*.

UnitedHealthcare will pay Benefits to you unless:

- the provider submits a claim form to UnitedHealthcare that you have provided signed authorization to assign Benefits directly to that provider; or
- you make a written request for the non-Network provider to be paid directly at the time you submit your claim.

UnitedHealthcare will only pay Benefits to you or, with written authorization by you, your Provider, and not to a third party, even if your provider purports to have assigned Benefits to that third party.

Health Statements

Each month in which UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at www.myuhc.com. See Section 14, *Glossary* for the definition of Explanation of Benefits.

Important - Timely Filing of Non-Network Claims

All claim forms for non-Network services must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Denials and Appeals

If Your Claim is Denied

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your ID card before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

UnitedHealthcare - Appeals
P.O. Box 30432
Salt Lake City, UT 84130-0432

For Urgent Care requests for Benefits that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- urgent care request for Benefits;
- pre-service request for Benefits;
- post-service claim; or
- concurrent claim.

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and

- a health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal determination.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor.

Federal External Review Program

If, after exhausting your internal appeals, you are not satisfied with the determination made by UnitedHealthcare, or if UnitedHealthcare fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of UnitedHealthcare's determination. The process is available at no charge to you.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- clinical reasons;
- the exclusions for Experimental or Investigational Services or Unproven Services;
- rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- as otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received UnitedHealthcare's decision.

An external review request should include all of the following:

- a specific request for an external review;
- the Covered Person's name, address, and insurance ID number;
- your designated representative's name and address, when applicable;
- the service that was denied; and
- any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). UnitedHealthcare has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- a standard external review; and
- an expedited external review.

Standard External Review

A standard external review is comprised of all of the following:

- a preliminary review by UnitedHealthcare of the request;
- a referral of the request by UnitedHealthcare to the IRO; and
- a decision by the IRO.

Within the applicable timeframe after receipt of the request, UnitedHealthcare will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- has exhausted the applicable internal appeals process; and
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the preliminary review, UnitedHealthcare will issue a notification in writing to you. If the request is eligible for external review, UnitedHealthcare will assign an IRO to conduct such review. UnitedHealthcare will assign requests by either rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

UnitedHealthcare will provide to the assigned IRO the documents and information considered in making UnitedHealthcare's determination. The documents include:

- all relevant medical records;
- all other documents relied upon by UnitedHealthcare; and
- all other information or evidence that you or your Physician submitted. If there is any information or evidence you or your Physician wish to submit that was not previously

provided, you may include this information with your external review request and UnitedHealthcare will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide written notice of its determination (the “Final External Review Decision”) within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and UnitedHealthcare, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing UnitedHealthcare determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited External Review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- an adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- a final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, UnitedHealthcare will determine whether the individual meets both of the following:

- is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- has provided all the information and forms required so that UnitedHealthcare may process the request.

After UnitedHealthcare completes the review, UnitedHealthcare will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, UnitedHealthcare will assign an IRO in the same manner UnitedHealthcare utilizes to assign standard external reviews to IROs. UnitedHealthcare will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by UnitedHealthcare. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to UnitedHealthcare.

You may contact UnitedHealthcare at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.

Timing of Appeals Determinations

Separate schedules apply to the timing of claims appeals, depending on the type of claim. There are three types of claims:

- Urgent Care request for Benefits - a request for Benefits provided in connection with Urgent Care services, as defined in Section 14, *Glossary*;
- Pre-Service request for Benefits - a request for Benefits which the Plan must approve or in which you must obtain prior authorization from UnitedHealthcare before non-Urgent Care is provided; and
- Post-Service - a claim for reimbursement of the cost of non-Urgent Care that has already been provided.

The tables below describe the time frames which you and UnitedHealthcare are required to follow.

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	24 hours
You must then provide completed request for Benefits to UnitedHealthcare within:	48 hours after receiving notice of additional information

TAFT STETTINIUS & HOLLISTER LLP MEDICAL CHOICE PLUS HRA PLAN

Urgent Care Request for Benefits*	
Type of Request for Benefits or Appeal	Timing
	required
UnitedHealthcare must notify you of the benefit determination within:	72 hours
If UnitedHealthcare denies your request for Benefits, you must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the appeal decision within:	72 hours after receiving the appeal

*You do not need to submit Urgent Care appeals in writing. You should call UnitedHealthcare as soon as possible to appeal an Urgent Care request for Benefits.

Pre-Service Request for Benefits	
Type of Request for Benefits or Appeal	Timing
If your request for Benefits is filed improperly, UnitedHealthcare must notify you within:	5 days
If your request for Benefits is incomplete, UnitedHealthcare must notify you within:	15 days
You must then provide completed request for Benefits information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial request for Benefits is complete, within:	15 days
■ after receiving the completed request for Benefits (if the initial request for Benefits is incomplete), within:	15 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	15 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	15 days after receiving the second level appeal

Post-Service Claims	
Type of Claim or Appeal	Timing
If your claim is incomplete, UnitedHealthcare must notify you within:	30 days
You must then provide completed claim information to UnitedHealthcare within:	45 days
UnitedHealthcare must notify you of the benefit determination:	
■ if the initial claim is complete, within:	30 days
■ after receiving the completed claim (if the initial claim is incomplete), within:	30 days
You must appeal an adverse benefit determination no later than:	180 days after receiving the adverse benefit determination
UnitedHealthcare must notify you of the first level appeal decision within:	30 days after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	60 days after receiving the first level appeal decision
UnitedHealthcare must notify you of the second level appeal decision within:	30 days after receiving the second level appeal

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care request for Benefits as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment.

UnitedHealthcare will make a determination on your request for the extended treatment within 24 hours from receipt of your request.

If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care request for Benefits and decided according to the timeframes described above. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new request and decided according to post-service or pre-service timeframes, whichever applies.

Limitation of Action

You cannot bring any legal action against Taft Stettinius & Hollister LLP or the Claims Administrator to recover reimbursement until 90 days after you have properly submitted a request for reimbursement as described in this section and all required reviews of your claim have been completed. If you want to bring a legal action against Taft Stettinius & Hollister LLP or the Claims Administrator, you must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or you lose any rights to bring such an action against Taft Stettinius & Hollister LLP or the Claims Administrator.

You cannot bring any legal action against Taft Stettinius & Hollister LLP or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against Taft Stettinius & Hollister LLP or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against Taft Stettinius & Hollister LLP or the Claims Administrator.

SECTION 10 - COORDINATION OF BENEFITS (COB)

What this section includes:

- How your Benefits under this Plan coordinate with other medical plans;
- How coverage is affected if you become eligible for Medicare; and
- Procedures in the event the Plan overpays Benefits.

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan, including any one of the following:

- another employer sponsored health benefits plan;
- a medical component of a group long-term care plan, such as skilled nursing care;
- no-fault or traditional "fault" type medical payment benefits or personal injury protection benefits under an auto insurance policy;
- medical payment benefits under any premises liability or other types of liability coverage; or
- Medicare or other governmental health benefit.

If coverage is provided under two or more plans, COB determines which plan is primary and which plan is secondary. The plan considered primary pays its benefits first, without regard to the possibility that another plan may cover some expenses. Any remaining expenses may be paid under the other plan, which is considered secondary. The secondary plan may determine its benefits based on the benefits paid by the primary plan.

Don't forget to update your Dependents' Medical Coverage Information

Avoid delays on your Dependent claims by updating your Dependent's medical coverage information. Just log on to www.myuhc.com or call the toll-free number on your ID card to update your COB information. You will need the name of your Dependent's other medical coverage, along with the policy number.

Determining Which Plan is Primary

If you are covered by two or more plans, the benefit payment follows the rules below in this order:

- this Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy;
- when you have coverage under two or more medical plans and only one has COB provisions, the plan without COB provisions will pay benefits first;
- a plan that covers a person as an employee pays benefits before a plan that covers the person as a dependent;
- if you are receiving COBRA continuation coverage under another employer plan, this Plan will pay Benefits first;

- your dependent children will receive primary coverage from the parent whose birth date occurs first in a calendar year. If both parents have the same birth date, the plan that pays benefits first is the one that has been in effect the longest. This birthday rule applies only if:
 - the parents are married or living together whether or not they have ever been married and not legally separated; or
 - a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage;
- if two or more plans cover a dependent child of divorced or separated parents and if there is no court decree stating that one parent is responsible for health care, the child will be covered under the plan of:
 - the parent with custody of the child; then
 - the Spouse of the parent with custody of the child; then
 - the parent not having custody of the child; then
 - the Spouse of the parent not having custody of the child;
- plans for active employees pay before plans covering laid-off or retired employees;
- the plan that has covered the individual claimant the longest will pay first; and
- finally, if none of the above rules determines which plan is primary or secondary, the allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

The following examples illustrate how the Plan determines which plan pays first and which plan pays second.

Determining Primary and Secondary Plan – Examples

- 1) Let's say you and your Spouse both have family medical coverage through your respective employers. You are unwell and go to see a Physician. Since you're covered as a Participant under this Plan, and as a Dependent under your Spouse's plan, this Plan will pay Benefits for the Physician's office visit first.
- 2) Again, let's say you and your Spouse both have family medical coverage through your respective employers. You take your Dependent child to see a Physician. This Plan will look at your birthday and your Spouse's birthday to determine which plan pays first. If you were born on June 11 and your Spouse was born on May 30, your Spouse's plan will pay first.

When This Plan is Secondary

If this Plan is secondary, it determines the amount it will pay for a Covered Health Service by following the steps below.

- the Plan determines the amount it would have paid based on the allowable expense.
- the Plan pays the entire difference between the allowable expense and the amount paid by the primary plan – as long as this amount is not more than the Plan would have paid had it been the only plan involved.

You will be responsible for any Coinsurance or Deductible payments as part of the COB payment. The maximum combined payment you may receive from all plans cannot exceed 100% of the total allowable expense. See the textbox below for the definition of allowable expense.

Determining the Allowable Expense If This Plan is Secondary

If this Plan is secondary, the allowable expense is the primary plan's Network rate. If the primary plan bases its reimbursement on reasonable and customary charges, the allowable expense is the primary plan's reasonable and customary charge. If both the primary plan and this Plan do not have a contracted rate, the allowable expense will be the greater of the two plans' reasonable and customary charges.

When the provider is a Network provider for both the primary plan and this Plan, the allowable expense is the primary plan's network rate. When the provider is a network provider for the primary plan and a non-Network provider for this Plan, the allowable expense is the primary plan's network rate. When the provider is a non-Network provider for the primary plan and a Network provider for this Plan, the allowable expense is the reasonable and customary charges allowed by the primary plan. When the provider is a non-Network provider for both the primary plan and this Plan, the allowable expense is the greater of the two Plans' reasonable and customary charges.

What is an allowable expense?

For purposes of COB, an allowable expense is a health care expense that is covered at least in part by one of the health benefit plans covering you.

When a Covered Person Qualifies for Medicare

Determining Which Plan is Primary

To the extent permitted by law, this Plan will pay Benefits second to Medicare when you become eligible for Medicare, even if you don't elect it. There are, however, Medicare-eligible individuals for whom the Plan pays Benefits first and Medicare pays benefits second:

- employees with active current employment status age 65 or older and their Spouses age 65 or older (however, Domestic Partners are excluded as provided by Medicare); and
- individuals with end-stage renal disease, for a limited period of time.

Determining the Allowable Expense When This Plan is Secondary to Medicare

If this Plan is secondary to Medicare, the Medicare approved amount is the allowable expense, as long as the provider accepts Medicare. If the provider does not accept Medicare, the Medicare limiting charge (the most a provider can charge you if they don't accept Medicare) will be the allowable expense. Medicare payments, combined with Plan Benefits, will not exceed 100% of the total allowable expense.

If you are eligible for, but not enrolled in, Medicare, and this Plan is secondary to Medicare, Benefits payable under this Plan will be reduced by the amount that would have been paid if you had been enrolled in Medicare.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. UnitedHealthcare may get the facts needed from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the person claiming benefits.

UnitedHealthcare does not need to tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give UnitedHealthcare any facts needed to apply those rules and determine benefits payable. If you do not provide UnitedHealthcare the information needed to apply these rules and determine the Benefits payable, your claim for Benefits will be denied.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount, by legal action if necessary.

Refund of Overpayments

If Taft Stettinius & Hollister LLP pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to Taft Stettinius & Hollister LLP if:

all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person;

all or some of the payment Taft Stettinius & Hollister LLP made exceeded the Benefits under the Plan; or

all or some of the payment was made in error.

The refund equals the amount Taft Stettinius & Hollister LLP paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help Taft Stettinius & Hollister LLP get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, Taft Stettinius & Hollister LLP may reduce the amount of any future

Benefits for the Covered Person that are payable under the Plan. The reductions will equal the amount of the required refund. Taft Stettinius & Hollister LLP may have other rights in addition to the right to reduce future Benefits.

Overpayment and Underpayment of Benefits

If you are covered under more than one medical plan, there is a possibility that the other plan will pay a benefit that UnitedHealthcare should have paid. If this occurs, the Plan may pay the other plan the amount owed.

If the Plan pays you more than it owes under this COB provision, you should pay the excess back promptly. Otherwise, the Company may recover the amount in the form of salary, wages, or benefits payable under any Company-sponsored benefit plans, including this Plan. The Company also reserves the right to recover any overpayment by legal action or offset payments on future Eligible Expenses.

If the Plan overpays a health care provider, UnitedHealthcare reserves the right to recover the excess amount from the provider pursuant to *Refund of Overpayments*, below.

Refund of Overpayments

If the Plan pays for Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to the Plan if:

- the Plan's obligation to pay Benefits was contingent on the expenses incurred being legally owed and paid by the Covered Person, but all or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- all or some of the payment the Plan made exceeded the Benefits under the Plan; or
- all or some of the payment was made in error.

The amount that must be refunded equals the amount the Plan paid in excess of the amount that should have been paid under the Plan. If the refund is due from another person or organization, the Covered Person agrees to help the Plan get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount owed, the Plan may recover the overpayment by reallocating the overpaid amount to pay, in whole or in part, (i) future Benefits for the Covered Person that are payable under the Plan; (ii) future Benefits that are payable to other Covered Persons under the Plan; or (iii) future benefits that are payable for services provided to persons under other plans for which UnitedHealthcare makes payments, with the understanding that UnitedHealthcare will then reimburse the Plan the amount of the reallocated payment. The reallocated payment amount will equal the amount of the required refund or, if less than the full amount of the required refund, will be deducted from the amount of refund owed to the Plan. The Plan may have other rights in addition to the right to reallocate overpaid amounts and other enumerated rights, including the right to commence a legal action.

SECTION 11 - SUBROGATION AND REIMBURSEMENT

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid Benefits on your behalf for a Sickness or Injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the Benefits that the Plan has paid that are related to the Sickness or Injury for which a third party is alleged to be responsible.

Subrogation – Example

Suppose you are injured in a car accident that is not your fault, and you receive Benefits under the Plan to treat your injuries. Under subrogation, the Plan has the right to take legal action in your name against the driver who caused the accident and that driver's insurance carrier to recover the cost of those Benefits.

The right to reimbursement means that if a third party causes or is alleged to have caused a Sickness or Injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any Benefits you received for that Sickness or Injury.

Reimbursement – Example

Suppose you are injured in a boating accident that is not your fault, and you receive Benefits under the Plan as a result of your injuries. In addition, you receive a settlement in a court proceeding from the individual who caused the accident. You must use the settlement funds to return to the plan 100% of any Benefits you received to treat your injuries.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a Sickness, Injury or damages, or who is legally responsible for the Sickness, Injury or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the Sickness, Injury or damages;
- the Plan Sponsor (for example workers' compensation cases);
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree as follows:

- You will cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable;
- providing any relevant information requested by the Plan;
- signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
- responding to requests for information about any accident or injuries;
- making court appearances;
- obtaining the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses; and
- complying with the terms of this section.

Your failure to cooperate with the Plan is considered a breach of contract. As such, the Plan has the right to terminate your Benefits, deny future Benefits, take legal action against you, and/or set off from any future Benefits the value of Benefits the Plan has paid relating to any Sickness or Injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

- The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.
- The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.
- Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.
- Benefits paid by the Plan may also be considered to be Benefits advanced.
- If you receive any payment from any party as a result of Sickness or Injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust

account. You agree that you will serve as a trustee over those funds to the extent of the Benefits the Plan has paid.

- The Plan's rights to recovery will not be reduced due to your own negligence.
- Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the Benefits the Plan has paid for the Sickness or Injury.
- The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.
- You may not accept any settlement that does not fully reimburse the Plan, without its written approval.
- The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.
- In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.
- No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
- The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.
- If a third party causes or is alleged to have caused you to suffer a Sickness or Injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.
- The Plan and all Administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Right of Recovery

The Plan has the right to recover benefits it has paid on you or your Dependent's behalf that were:

- made in error;
- due to a mistake in fact;
- advanced during the time period of meeting the calendar year Deductible; or

- advanced during the time period of meeting the Out-of-Pocket Maximum for the calendar year.

Benefits paid because you or your Dependent misrepresented facts are also subject to recovery.

If the Plan provides a Benefit for you or your Dependent that exceeds the amount that should have been paid, the Plan will:

- require that the overpayment be returned when requested, or
- reduce a future benefit payment for you or your Dependent by the amount of the overpayment.

If the Plan provides an advancement of benefits to you or your Dependent during the time period of meeting the Deductible and/or meeting the Out-of-Pocket Maximum for the calendar year, the Plan will send you or your Dependent a monthly statement identifying the amount you owe with payment instructions. The Plan has the right to recover Benefits it has advanced by:

- submitting a reminder letter to you or a covered Dependent that details any outstanding balance owed to the Plan; and
- conducting courtesy calls to you or a covered Dependent to discuss any outstanding balance owed to the Plan.

SECTION 12 - WHEN COVERAGE ENDS

What this section includes:

- Circumstances that cause coverage to end;
- Extended coverage; and
- How to continue coverage after it ends.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

When your coverage ends, Taft Stettinius & Hollister LLP will still pay claims for Covered Health Services that you received before your coverage ended. However, once your coverage ends, Benefits are not provided for health services that you receive after coverage ended, even if the underlying medical condition occurred before your coverage ended. Please note that this does not affect coverage that is extended under *Extended Coverage for Total Disability* below.

Your coverage under the Plan will end on the earliest of:

- the date your employment with the Company ends;
- the date the Plan ends;
- the date you stop making the required contributions;
- the date you are no longer eligible;
- the date UnitedHealthcare receives written notice from Taft Stettinius & Hollister LLP to end your coverage, or the date requested in the notice, if later; or
- the date you retire or are pensioned under the Plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible Dependents will end on the earliest of:

- the date your coverage ends;
- the date you stop making the required contributions;
- the date UnitedHealthcare receives written notice from Taft Stettinius & Hollister LLP to end your coverage, or the date requested in the notice, if later; or
- the date your Dependents no longer qualify as Dependents under this Plan.

Other Events Ending Your Coverage

The Plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- you commit an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a Dependent; or
- you commit an act of physical or verbal abuse that imposes a threat to Taft Stettinius & Hollister LLP's staff, UnitedHealthcare's staff, a provider or another Covered Person.

Note: Taft Stettinius & Hollister LLP has the right to demand that you pay back Benefits Taft Stettinius & Hollister LLP paid to you, or paid in your name, during the time you were incorrectly covered under the Plan.

Coverage for a Disabled Child

If an unmarried enrolled Dependent child with a mental or physical disability reaches an age when coverage would otherwise end, the Plan will continue to cover the child, as long as:

- the child is unable to be self-supporting due to a mental or physical handicap or disability;
- the child depends mainly on you for support;
- you provide to Taft Stettinius & Hollister LLP proof of the child's incapacity and dependency within 31 days of the date coverage would have otherwise ended because the child reached a certain age; and
- you provide proof, upon Taft Stettinius & Hollister LLP's request, that the child continues to meet these conditions.

The proof might include medical examinations at Taft Stettinius & Hollister LLP's expense. However, you will not be asked for this information more than once a year. If you do not supply such proof within 31 days, the Plan will no longer pay Benefits for that child.

Coverage will continue, as long as the enrolled Dependent is incapacitated and dependent upon you, unless coverage is otherwise terminated in accordance with the terms of the Plan.

Extended Coverage for Total Disability

If you are an inpatient in a hospital, skilled nursing facility, or inpatient rehabilitation facility at the time coverage under the policy would otherwise end, as described above, your benefits will be temporarily extended. Benefits will be extended only for the treatment of the condition that has caused the inpatient stay.

Benefits will be extended until the earliest of the following dates: The date you are discharged from the inpatient stay, the date you reach any maximum benefit limit that applies, the day your physician determines that the inpatient stay is no longer necessary or appropriate, or the effective date of any new coverage. These benefits are subject to all

terms, conditions, limitations, and exclusions of the policy that is in effect on the day immediately prior to the date coverage would otherwise end.

Continuing Coverage Through COBRA

If you lose your Plan coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA), as defined in Section 14, *Glossary*.

Continuation coverage under COBRA is available only to Plans that are subject to the terms of COBRA. You can contact your Plan Administrator to determine if Taft Stettinius & Hollister LLP is subject to the provisions of COBRA.

Continuation Coverage under Federal Law (COBRA)

Much of the language in this section comes from the federal law that governs continuation coverage. You should call your Plan Administrator if you have questions about your right to continue coverage.

In order to be eligible for continuation coverage under federal law, you must meet the definition of a "Qualified Beneficiary". A Qualified Beneficiary is any of the following persons who were covered under the Plan on the day before a qualifying event:

- a Participant;
- a Participant's enrolled Dependent, including with respect to the Participant's children, a child born to or placed for adoption with the Participant during a period of continuation coverage under federal law; or
- a Participant's former Spouse.

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months

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If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA:		
	For Yourself	For Your Spouse	For Your Child(ren)
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing coverage ¹	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
Taft Stettinius & Hollister LLP files for bankruptcy under Title 11, United States Code. ²	36 months	36 months ³	36 months ³

¹Subject to the following conditions: (i) notice of the disability must be provided within the latest of 60 days after a). the determination of the disability, b). the date of the qualifying event, c). the date the Qualified Beneficiary would lose coverage under the Plan, and in no event later than the end of the first 18 months; (ii) the Qualified Beneficiary must agree to pay any increase in the required premium for the additional 11 months over the original 18 months; and (iii) if the Qualified Beneficiary entitled to the 11 months of coverage has non-disabled family members who are also Qualified Beneficiaries, then those non-disabled Qualified Beneficiaries are also entitled to the additional 11 months of continuation coverage. Notice of any final determination that the Qualified Beneficiary is no longer disabled must be provided within 30 days of such determination. Thereafter, continuation coverage may be terminated on the first day of the month that begins more than 30 days after the date of that determination.

²This is a qualifying event for any Retired Participant and his or her enrolled Dependents if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed.

³From the date of the Participant's death if the Participant dies during the continuation coverage.

How Your Medicare Eligibility Affects Dependent COBRA Coverage

The table below outlines how your Dependents' COBRA coverage is impacted if you become entitled to Medicare.

If Dependent Coverage Ends When:	You May Elect COBRA Dependent Coverage For Up To:
You become entitled to Medicare and don't experience any additional qualifying events	18 months
You become entitled to Medicare, after which you experience a second qualifying event* before the initial 18-month period expires	36 months
You experience a qualifying event*, after which you become entitled to Medicare before the initial 18-month period expires; and, if absent this initial qualifying event, your Medicare entitlement would have resulted in loss of Dependent coverage under the Plan	36 months

* Your work hours are reduced or your employment is terminated for reasons other than gross misconduct.

Getting Started

You will be notified by mail if you become eligible for COBRA coverage as a result of a reduction in work hours or termination of employment. The notification will give you instructions for electing COBRA coverage, and advise you of the monthly cost. Your monthly cost is the full cost, including both Participant and Employer costs, plus a 2% administrative fee or other cost as permitted by law.

You will have up to 60 days from the date you receive notification or 60 days from the date your coverage ends to elect COBRA coverage, whichever is later. You will then have an additional 45 days to pay the cost of your COBRA coverage, retroactive to the date your Plan coverage ended.

During the 60-day election period, the Plan will, only in response to a request from a provider, inform that provider of your right to elect COBRA coverage, retroactive to the date your COBRA eligibility began.

While you are a participant in the medical Plan under COBRA, you have the right to change your coverage election:

- during Open Enrollment; and
- following a change in family status, as described under *Changing Your Coverage* in Section 2, *Introduction*.

Notification Requirements

If your covered Dependents lose coverage due to divorce, legal separation, or loss of Dependent status, you or your Dependents must notify the Plan Administrator within 60 days of the latest of:

- the date of the divorce, legal separation or an enrolled Dependent's loss of eligibility as an enrolled Dependent;
- the date your enrolled Dependent would lose coverage under the Plan; or
- the date on which you or your enrolled Dependent are informed of your obligation to provide notice and the procedures for providing such notice.

You or your Dependents must also notify the Plan Administrator when a qualifying event occurs that will extend continuation coverage.

If you or your Dependents fail to notify the Plan Administrator of these events within the 60 day period, the Plan Administrator is not obligated to provide continued coverage to the affected Qualified Beneficiary. If you are continuing coverage under federal law, you must notify the Plan Administrator within 60 days of the birth or adoption of a child.

Once you have notified the Plan Administrator, you will then be notified by mail of your election rights under COBRA.

Notification Requirements for Disability Determination

If you extend your COBRA coverage beyond 18 months because you are eligible for disability benefits from Social Security, you must provide Human Resources with notice of the Social Security Administration's determination within 60 days after you receive that determination, and before the end of your initial 18-month continuation period.

The notice requirements will be satisfied by providing written notice to the Plan Administrator at the address stated in Section 17, *Important Administrative Information: ERISA*. The contents of the notice must be such that the Plan Administrator is able to determine the covered Employee and qualified beneficiary(ies), the qualifying event or disability, and the date on which the qualifying event occurred.

Trade Act of 2002

The Trade Act of 2002 amended COBRA to provide for a special second 60-day COBRA election period for certain Participants who have experienced a termination or reduction of hours and who lose group health plan coverage as a result. The special second COBRA election period is available only to a very limited group of individuals: generally, those who are receiving trade adjustment assistance (TAA) or 'alternative trade adjustment assistance' under a federal law called the Trade Act of 1974. These Participants are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days from the first day of the month when an individual begins receiving TAA (or would be eligible to receive TAA but for the requirement that unemployment benefits be exhausted) and only during the six months immediately after their group health plan coverage ended.

If a Participant qualifies or may qualify for assistance under the Trade Act of 1974, he or she should contact the Plan Administrator for additional information. The Participant must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 1974 or the Participant will lose his or her special COBRA rights. COBRA coverage elected during the special second election period is not retroactive to the date that Plan coverage was lost, but begins on the first day of the special second election period.

When COBRA Ends

COBRA coverage will end before the maximum continuation period shown above if:

you or your covered Dependent becomes covered under another group medical plan, as long as the other plan doesn't limit your coverage due to a preexisting condition; or if the other plan does exclude coverage due to your preexisting condition, your COBRA benefits would end when the exclusion period ends;

you or your covered Dependent becomes entitled to, and enrolls in, Medicare after electing COBRA;

the first required premium is not paid within 45 days;

any other monthly premium is not paid within 30 days of its due date;

the entire Plan ends; or

coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

COBRA coverage will end, before the maximum continuation period, on the earliest of the following dates:

- the date, after electing continuation coverage, that coverage is first obtained under any other group health plan;
- the date, after electing continuation coverage, that you or your covered Dependent first becomes entitled to Medicare;
- the date coverage ends for failure to make the first required premium (premium is not paid within 45 days);
- the date coverage ends for failure to make any other monthly premium (premium is not paid within 30 days of its due date);
- the date the entire Plan ends; or
- the date coverage would otherwise terminate under the Plan as described in the beginning of this section.

Note: If you selected continuation coverage under a prior plan which was then replaced by coverage under this Plan, continuation coverage will end as scheduled under the prior plan or in accordance with the terminating events listed in this section, whichever is earlier.

Uniformed Services Employment and Reemployment Rights Act

A Participant who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the Participant and the Participant's Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, Participants may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on a Participant's behalf. If a Participant's Military Service is for a period of time less than 31 days, the Participant may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

A Participant may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the Participant's absence from work; or
- the day after the date on which the Participant fails to apply for, or return to, a position of employment.

Regardless of whether a Participant continues health coverage, if the Participant returns to a position of employment, the Participant's health coverage and that of the Participant's eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on a Participant or the Participant's eligible Dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

SECTION 13 - OTHER IMPORTANT INFORMATION

What this section includes:

- Court-ordered Benefits for Dependent children;
- Your relationship with UnitedHealthcare and Taft Stettinius & Hollister LLP;
- Relationships with providers;
- Interpretation of Benefits;
- Information and records;
- Incentives to providers and you;
- The future of the Plan; and
- How to access the official Plan documents.

Qualified Medical Child Support Orders (QMCSOs)

A qualified medical child support order (QMCSO) is a judgment, decree or order issued by a court or appropriate state agency that requires a child to be covered for medical benefits. Generally, a QMCSO is issued as part of a paternity, divorce, or other child support settlement.

If the Plan receives a medical child support order for your child that instructs the Plan to cover the child, the Plan Administrator will review it to determine if it meets the requirements for a QMCSO. If it determines that it does, your child will be enrolled in the Plan as your Dependent, and the Plan will be required to pay Benefits as directed by the order.

You may obtain, without charge, a copy of the procedures governing QMCSOs from the Plan Administrator.

Note: A National Medical Support Notice will be recognized as a QMCSO if it meets the requirements of a QMCSO.

Your Relationship with UnitedHealthcare and Taft Stettinius & Hollister LLP

In order to make choices about your health care coverage and treatment, Taft Stettinius & Hollister LLP believes that it is important for you to understand how UnitedHealthcare interacts with the Plan Sponsor's benefit Plan and how it may affect you. UnitedHealthcare helps administer the Plan Sponsor's benefit plan in which you are enrolled. UnitedHealthcare does not provide medical services or make treatment decisions. This means:

- UnitedHealthcare communicates to you decisions about whether the Plan will cover or pay for the health care that you may receive (the Plan pays for Covered Health Services, which are more fully described in this SPD); and
- the Plan may not pay for all treatments you or your Physician may believe are necessary. If the Plan does not pay, you will be responsible for the cost.

Taft Stettinius & Hollister LLP and UnitedHealthcare may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. Taft Stettinius & Hollister LLP and UnitedHealthcare will use individually identifiable information about you as permitted or required by law, including in operations and in research. Taft Stettinius & Hollister LLP and UnitedHealthcare will use de-identified data for commercial purposes including research.

Relationship with Providers

The relationships between Taft Stettinius & Hollister LLP, UnitedHealthcare and Network providers are solely contractual relationships between independent contractors. Network providers are not Taft Stettinius & Hollister LLP's agents or employees, nor are they agents or employees of UnitedHealthcare. Taft Stettinius & Hollister LLP and any of its employees are not agents or employees of Network providers, nor are UnitedHealthcare and any of its employees agents or employees of Network providers.

Taft Stettinius & Hollister LLP and UnitedHealthcare do not provide health care services or supplies, nor do they practice medicine. Instead, Taft Stettinius & Hollister LLP and UnitedHealthcare arrange for health care providers to participate in a Network and pay Benefits. Network providers are independent practitioners who run their own offices and facilities. UnitedHealthcare's credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not Taft Stettinius & Hollister LLP's employees nor are they employees of UnitedHealthcare. Taft Stettinius & Hollister LLP and UnitedHealthcare do not have any other relationship with Network providers such as principal-agent or joint venture. Taft Stettinius & Hollister LLP and UnitedHealthcare are not liable for any act or omission of any provider.

UnitedHealthcare is not considered to be an employer of the Plan Administrator for any purpose with respect to the administration or provision of benefits under this Plan.

Taft Stettinius & Hollister LLP is solely responsible for:

- enrollment and classification changes (including classification changes resulting in your enrollment or the termination of your coverage);
- the timely payment of Benefits; and
- notifying you of the termination or modifications to the Plan.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient. Your provider is solely responsible for the quality of the services provided to you. You:

- are responsible for choosing your own provider;
- are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Coinsurance, any Annual Deductible and any amount that exceeds Eligible Expenses;

- are responsible for paying, directly to your provider, the cost of any non-Covered Health Service;
- must decide if any provider treating you is right for you (this includes Network providers you choose and providers to whom you have been referred); and
- must decide with your provider what care you should receive.

Interpretation of Benefits

Taft Stettinius & Hollister LLP and UnitedHealthcare have the sole and exclusive discretion to:

- interpret Benefits under the Plan;
- interpret the other terms, conditions, limitations and exclusions of the Plan, including this SPD and any Riders and/or Amendments; and
- make factual determinations related to the Plan and its Benefits.

Taft Stettinius & Hollister LLP and UnitedHealthcare may delegate this discretionary authority to other persons or entities that provide services in regard to the administration of the Plan.

In certain circumstances, for purposes of overall cost savings or efficiency, Taft Stettinius & Hollister LLP may, in its discretion, offer Benefits for services that would otherwise not be Covered Health Services. The fact that Taft Stettinius & Hollister LLP does so in any particular case shall not in any way be deemed to require Taft Stettinius & Hollister LLP to do so in other similar cases.

Information and Records

Taft Stettinius & Hollister LLP and UnitedHealthcare may use your individually identifiable health information to administer the Plan and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. Taft Stettinius & Hollister LLP and UnitedHealthcare may request additional information from you to decide your claim for Benefits. Taft Stettinius & Hollister LLP and UnitedHealthcare will keep this information confidential. Taft Stettinius & Hollister LLP and UnitedHealthcare may also use your de-identified data for commercial purposes, including research, as permitted by law.

By accepting Benefits under the Plan, you authorize and direct any person or institution that has provided services to you to furnish Taft Stettinius & Hollister LLP and UnitedHealthcare with all information or copies of records relating to the services provided to you. Taft Stettinius & Hollister LLP and UnitedHealthcare have the right to request this information at any reasonable time. This applies to all Covered Persons, including enrolled Dependents whether or not they have signed the Participant's enrollment form. Taft Stettinius & Hollister LLP and UnitedHealthcare agree that such information and records will be considered confidential.

Taft Stettinius & Hollister LLP and UnitedHealthcare have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of the Plan, for appropriate medical review or quality assessment, or as Taft Stettinius & Hollister LLP is required to do by law or regulation. During and after the term of the Plan, Taft Stettinius & Hollister LLP and UnitedHealthcare and its related entities may use and transfer the information gathered under the Plan in a de-identified format for commercial purposes, including research and analytic purposes.

For complete listings of your medical records or billing statements Taft Stettinius & Hollister LLP recommends that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from UnitedHealthcare, they also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, Taft Stettinius & Hollister LLP and UnitedHealthcare will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. UnitedHealthcare's designees have the same rights to this information as does the Plan Administrator.

Incentives to Providers

Network providers may be provided financial incentives by UnitedHealthcare to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- bonuses for performance based on factors that may include quality, member satisfaction, and/or cost-effectiveness; or
- a practice called capitation which is when a group of Network providers receives a monthly payment from UnitedHealthcare for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

If you have any questions regarding financial incentives you may contact the telephone number on your ID card. You can ask whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed. In addition, you may choose to discuss these financial incentives with your Network provider.

Incentives to You

Sometimes you may be offered coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but Taft Stettinius & Hollister LLP recommends that you discuss participating in such programs with your Physician. These incentives are not

Benefits and do not alter or affect your Benefits. You may call the number on the back of your ID card if you have any questions.

Rebates and Other Payments

Taft Stettinius & Hollister LLP and UnitedHealthcare may receive rebates for certain drugs that are administered to you in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet your Annual Deductible. Taft Stettinius & Hollister LLP and UnitedHealthcare do not pass these rebates on to you, nor are they applied to your Annual Deductible or taken into account in determining your Coinsurance.

Workers' Compensation Not Affected

Benefits provided under the Plan do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Future of the Plan

Although the Company expects to continue the Plan indefinitely, it reserves the right to discontinue, alter or modify the Plan in whole or in part, at any time and for any reason, at its sole determination.

The Company's decision to terminate or amend a Plan may be due to changes in federal or state laws governing employee benefits, the requirements of the Internal Revenue Code or Employee Retirement Income Security Act of 1974 (ERISA), or any other reason. A plan change may transfer plan assets and debts to another plan or split a plan into two or more parts. If the Company does change or terminate a plan, it may decide to set up a different plan providing similar or different benefits.

If this Plan is terminated, Covered Persons will not have the right to any other Benefits from the Plan, other than for those claims incurred prior to the date of termination, or as otherwise provided under the Plan. In addition, if the Plan is amended, Covered Persons may be subject to altered coverage and Benefits.

The amount and form of any final benefit you receive will depend on any Plan document or contract provisions affecting the Plan and Company decisions. After all Benefits have been paid and other requirements of the law have been met, certain remaining Plan assets will be turned over to the Company and others as may be required by any applicable law.

Plan Document

This Summary Plan Description (SPD) represents an overview of your Benefits. In the event there is a discrepancy between the SPD and the official plan document, the plan document will govern. A copy of the plan document is available for your inspection during regular business hours in the office of the Plan Administrator. You (or your personal representative) may obtain a copy of this document by written request to the Plan Administrator, for a nominal charge.

SECTION 14 - GLOSSARY

What this section includes:

- Definitions of terms used throughout this SPD.

Many of the terms used throughout this SPD may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how Benefits are paid. This section defines terms used throughout this SPD, but it does not describe the Benefits provided by the Plan.

Addendum – any attached written description of additional or revised provisions to the Plan. The benefits and exclusions of this SPD and any amendments thereto shall apply to the Addendum except that in the case of any conflict between the Addendum and SPD and/or Amendments to the SPD, the Addendum shall be controlling.

Alternate Facility – a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- surgical services;
- Emergency Health Services; or
- rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health or Substance Use Disorder Services on an outpatient basis or inpatient basis (for example a Residential Treatment Facility).

Amendment – any attached written description of additional or alternative provisions to the Plan. Amendments are effective only when distributed by the Plan Sponsor or the Plan Administrator. Amendments are subject to all conditions, limitations and exclusions of the Plan, except for those that the amendment is specifically changing.

Annual Deductible (or Deductible) – the amount you must pay for Covered Health Services in a plan year before the Plan will begin paying Benefits in that plan year. The Deductible is shown in the first table in Section 5, *Plan Highlights*.

Autism Spectrum Disorders – a group of neurobiological disorders that includes *Autistic Disorder, Rbett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS)*.

Autism Spectrum Disorders - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Benefits – Plan payments for Covered Health Services, subject to the terms and conditions of the Plan and any Addendums and/or Amendments.

Cancer Resource Services (CRS) – a program administered by UnitedHealthcare or its affiliates made available to you by Taft Stettinius & Hollister LLP. The CRS program provides:

- specialized consulting services, on a limited basis, to Participants and enrolled Dependents with cancer;
- access to cancer centers with expertise in treating the most rare or complex cancers; and
- education to help patients understand their cancer and make informed decisions about their care and course of treatment.

Certificate of Creditable Coverage—A document furnished by a group health plan or a health insurance company that shows the amount of time the individual has had coverage. This document is used to reduce or eliminate the length of time a preexisting condition exclusion applies.

CHD – see Congenital Heart Disease (CHD).

Claims Administrator – UnitedHealthcare (also known as United HealthCare Services, Inc.) and its affiliates, who provide certain claim administration services for the Plan.

Clinical Trial – a scientific study designed to identify new health services that improve health outcomes. In a Clinical Trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

COBRA – see Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Coinsurance – the percentage of Eligible Expenses you are required to pay for certain Covered Health Services as described in Section 3, *How the Plan Works*.

Company – Taft Stettinius & Hollister LLP.

Congenital Anomaly – a physical developmental defect that is present at birth and is identified within the first twelve months of birth.

Congenital Heart Disease (CHD) – any structural heart problem or abnormality that has been present since birth. Congenital heart defects may:

- be passed from a parent to a child (inherited);
- develop in the fetus of a woman who has an infection or is exposed to radiation or other toxic substances during her Pregnancy; or
- have no known cause.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – a federal law that requires employers to offer continued health insurance coverage to certain employees and their dependents whose group health insurance has been terminated.

Cosmetic Procedures – procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator. Reshaping a nose with a prominent bump is a good example of a Cosmetic Procedure because appearance would be improved, but there would be no improvement in function like breathing.

Cost-Effective – the least expensive equipment that performs the necessary function. This term applies to Durable Medical Equipment and prosthetic devices.

Covered Health Services – those health services, including services, supplies or Pharmaceutical Products, which UnitedHealthcare determines to be:

- Medically Necessary;
- included in Sections 5 and 6, *Plan Highlights* and *Additional Coverage Details* described as a Covered Health Service;
- provided to a Covered Person who meets the Plan's eligibility requirements, as described under *Eligibility* in Section 2, *Introduction*; and
- not identified in Section 8, *Exclusions*.

Covered Person – either the Participant or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to "you" and "your" throughout this SPD are references to a Covered Person.

CRS – see Cancer Resource Services (CRS).

Custodial Care – services that do not require special skills or training and that:

- provide assistance in activities of daily living (including but not limited to feeding, dressing, bathing, ostomy care, incontinence care, checking of routine vital signs, transferring and ambulating);
- are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence; or
- do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Deductible – see Annual Deductible.

Dependent – an individual who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Dependent does not include anyone who is also enrolled as a Participant. No one can be a Dependent of more than one Participant.

Designated Facility – a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within your geographic area.

To be considered a Designated Facility, a facility must meet certain standards of excellence and have a proven track record of treating specified conditions.

DME – see Durable Medical Equipment (DME).

Domestic Partner – an individual of the same sex with whom you have established a domestic partnership as described below.

A domestic partnership is a relationship between a Participant and one other person of the same sex. Both persons must:

- not be so closely related that marriage would otherwise be prohibited;
- not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
- be at least 18 years old;
- live together and share the common necessities of life;
- be mentally competent to enter into a contract; and
- be financially interdependent.

The Participant and Domestic Partner must jointly sign an affidavit of domestic partnership provided by Human Resources upon your request.

Domiciliary Care – living arrangements designed to meet the needs of people who cannot live independently but do not require Skilled Nursing Facility services.

Durable Medical Equipment (DME) – medical equipment that is all of the following:

- used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- not disposable;
- not of use to a person in the absence of a Sickness, Injury or their symptoms;
- durable enough to withstand repeated use;
- not implantable within the body; and
- appropriate for use, and primarily used, within the home.

Eligible Expenses – charges for Covered Health Services that are provided while the Plan is in effect, determined as follows:

For Services Provided by a:	Eligible Expenses are Based On:
Network Provider	Contracted rates with the provider
Non Network Provider	negotiated rates agreed to by the non Network provider and either the Claims Administrator or one of its vendors, affiliates or subcontractors, at the discretion of the Claims

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For Services Provided by a:	Eligible Expenses are Based On:
	Administrator.
	<p>if rates have not been negotiated, then one of the following amounts:</p> <ul style="list-style-type: none"> 110 percent of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market, or
	<ul style="list-style-type: none"> When a rate is not published by CMS for the service, the Claims Administrator uses an available gap methodology to determine a rate for the service as follows: <ul style="list-style-type: none"> For services other than Pharmaceutical Products, the Claims Administrator uses a gap methodology that uses a relative value scale, which is usually based on the difficulty, time, work, risk and resources of the service. The relative value scale currently used is created by Ingenix, Inc. If the Ingenix, Inc. relative value scale becomes no longer available, a comparable scale will be used. The Claims Administrator and Ingenix, Inc. are related companies through common ownership by UnitedHealth Group. For Pharmaceutical Products, the Claims Administrator uses gap methodologies that are similar to the pricing methodology used by CMS, and produces fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or the Claims Administrator based on an internally developed pharmaceutical pricing resource. When a rate is not published by CMS for the service and a gap methodology does not apply to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or a gap methodology, the Eligible Expense is based on 50 percent of the provider's billed charge, except that certain Eligible Expenses for mental health and substance use disorder services are based on 80 percent of the billed charge.

TAFT STETTINIUS & HOLLISTER LLP MEDICAL CHOICE PLUS HRA PLAN

For Services Provided by a:	Eligible Expenses are Based On:
	<p data-bbox="656 291 1281 501">For Mental Health Services and Substance Use Disorder Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.</p> <p data-bbox="607 512 1330 690">The Claims Administrator updates the CMS published rate data on a regular basis when updated data from CMS becomes available. These updates are typically implemented within 30 to 90 days after CMS updates its data.</p> <p data-bbox="607 716 1265 890">These provisions do not apply if you receive Covered Health Services from a non Network provider in an Emergency. In that case, Eligible Expenses are the amounts billed by the provider, unless the Claims Administrator negotiates lower rates.</p>

For certain Covered Health Services, you are required to pay a percentage of Eligible Expenses in the form of Coinsurance.

Eligible Expenses are subject to the Claims Administrator's reimbursement policy guidelines. You may request a copy of the guidelines related to your claim from the Claims Administrator.

IMPORTANT NOTICE

Non Network Physicians and providers may bill you for any difference between the Physician's or provider's billed charges and the Eligible Expense described above.

Eligible Expenses – for Covered Health Services, incurred while the Plan is in effect, Eligible Expenses are determined by UnitedHealthcare as stated below and as detailed in Section 3, *How the Plan Works*.

Eligible Expenses are determined solely in accordance with UnitedHealthcare's reimbursement policy guidelines. UnitedHealthcare develops the reimbursement policy guidelines, in UnitedHealthcare's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.

- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that UnitedHealthcare accepts.

Emergency – a serious medical condition or symptom resulting from Injury, Sickness or Mental Illness, or substance use disorders which:

- arises suddenly; and
- in the judgment of a reasonable person, requires immediate care and treatment, generally received within 24 hours of onset, to avoid jeopardy to life or health.

Emergency Health Services – health care services and supplies necessary for the treatment of an Emergency.

Employee Retirement Income Security Act of 1974 (ERISA) – the federal legislation that regulates retirement and employee welfare benefit programs maintained by employers and unions.

Employer – Taft Stettinius & Hollister LLP.

EOB – see Explanation of Benefits (EOB).

ERISA – see Employee Retirement Income Security Act of 1974 (ERISA).

Experimental or Investigational Services – medical, surgical, diagnostic, psychiatric, mental health, substance use disorders substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational); or
- the subject of an ongoing Clinical Trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in Section 6, *Additional Coverage Details*.
- If you are not a participant in a qualifying Clinical Trial as described under Section 6, *Additional Coverage Details*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment, the Claims Administrator may, at its

discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such consideration, the Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Explanation of Benefits (EOB) – a statement provided by UnitedHealthcare to you, your Physician, or another health care professional that explains:

- the Benefits provided (if any);
- the allowable reimbursement amounts;
- Deductibles;
- Coinsurance;
- any other reductions taken;
- the net amount paid by the Plan; and
- the reason(s) why the service or supply was not covered by the Plan.

Genetic Testing – examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Health Statement(s) – a single, integrated statement that summarizes EOB information by providing detailed content on account balances and claim activity.

Home Health Agency – a program or organization authorized by law to provide health care services in the home.

Hospital – an institution, operated as required by law, which is:

- primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of sick or injured individuals. Care is provided through medical, mental health, substance use disorders, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians; and
- has 24 hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a Skilled Nursing Facility, convalescent home or similar institution.

Injury – bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility – a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay – an uninterrupted confinement, following formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment—a structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital based and provides services for at least three hours per day, two or more days per week.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care – skilled nursing care that is provided or needed either:

- fewer than seven days each week; or
- fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in special circumstances when the need for additional care is finite and predictable.

Kidney Resource Services (KRS) – a program administered by UnitedHealthcare or its affiliates made available to you by Taft Stettinius & Hollister LLP. The KRS program provides:

- specialized consulting services to Participants and enrolled Dependents with ESRD or chronic kidney disease;
- access to dialysis centers with expertise in treating kidney disease; and
- guidance for the patient on the prescribed plan of care.

Manipulative Treatment – the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods rendered to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medicaid – a federal program administered and operated individually by participating state and territorial governments that provides medical benefits to eligible low-income people needing health care. The federal and state governments share the program's costs.

Medically Necessary—healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by UnitedHealthcare or its designee, within UnitedHealthcare's sole discretion. The services must be:

in accordance with Generally Accepted Standards of Medical Practice;

clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance use disorder disease or its symptoms;

not mainly for your convenience or that of your doctor or other health care provider; and

not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within UnitedHealthcare's sole discretion.

UnitedHealthcare develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

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Medicare – Parts A, B, C and D of the insurance program established by Title XVIII, United States Social Security Act, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services – Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance Use Disorder (MH/SUD) Administrator – the organization or individual designated by Taft Stettinius & Hollister LLP who provides or arranges Mental Health and Substance Use Disorder Services under the Plan.

Mental Illness – mental health or psychiatric diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless they are listed in Section 8, *Exclusions*.

Network – when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with the Claims Administrator or with its affiliate to participate in the Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services by way of their participation in the Shared Savings Program. The Claims Administrator's affiliates are those entities affiliated with the Claims Administrator through common ownership or control with the Claims Administrator or with the Claims Administrator's ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Benefits - description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to Section 5, *Plan Highlights* for details about how Network Benefits apply.

Non-Network Benefits - description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to Section 5, *Plan Highlights* for details about how Non-Network Benefits apply.

Open Enrollment – the period of time, determined by Taft Stettinius & Hollister LLP, during which eligible Participants may enroll themselves and their Dependents under the Plan. Taft Stettinius & Hollister LLP determines the period of time that is the Open Enrollment period.

Out-of-Pocket Maximum – the maximum amount you pay every plan year. Refer to Section 5, *Plan Highlights* for the Out-of-Pocket Maximum amount. See Section 3, *How the Plan Works* for a description of how the Out-of-Pocket Maximum works.

Partial Hospitalization/Day Treatment – a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Participant – a full-time Participant of the Employer who meets the eligibility requirements specified in the Plan, as described under *Eligibility* in Section 2, *Introduction*. A Participant must live and/or work in the United States.

Personal Health Support – programs provided by the Claims Administrator that focus on prevention, education, and closing the gaps in care designed to encourage an efficient system of care for you and your covered Dependents.

Personal Health Support Nurse – the primary nurse that UnitedHealthcare may assign to you if you have a chronic or complex health condition. If a Personal Health Support Nurse is assigned to you, this nurse will call you to assess your progress and provide you with information and education.

Pharmaceutical Products – U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under the Plan.

Physician – any Doctor of Medicine or Doctor of Osteopathy who is properly licensed and qualified by law.

Please note: Any podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that a provider is described as a Physician does not mean that Benefits for services from that provider are available to you under the Plan.

Plan – The Taft Stettinius & Hollister LLP Medical Plan.

Plan Administrator – Taft Stettinius & Hollister LLP or its designee.

Plan Sponsor – Taft Stettinius & Hollister LLP.

Pregnancy – includes prenatal care, postnatal care, childbirth, and any complications associated with the above.

Private Duty Nursing – nursing care that is provided to a patient on a one-to-one basis by licensed nurses in an inpatient or a home setting when any of the following are true:

- no skilled services are identified;
- skilled nursing resources are available in the facility;
- the skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose; or
- the service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or a home-care basis, whether the service is skilled or non-skilled independent nursing.

Reconstructive Procedure – a procedure performed to address a physical impairment where the expected outcome is restored or improved function. The primary purpose of a Reconstructive Procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive Procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly. The primary result of the procedure is not changed or improved physical appearance. The fact that a person may suffer psychologically as a result of the impairment does not classify surgery or any other procedure done to relieve the impairment as a Reconstructive Procedure.

Residential Treatment Facility – a facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- it is established and operated in accordance with applicable state law for residential treatment programs;
- it provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance Use Disorder Administrator;
- it has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient; and
- it provides at least the following basic services in a 24-hour per day, structured milieu:
 - room and board;
 - evaluation and diagnosis;
 - counseling; and
 - referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Retired Employee – an Employee who retires while covered under the Plan.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Shared Savings Program - the Shared Savings Program provides access to discounts from non-Network Physicians who participate in that program. UnitedHealthcare will use the Shared Savings Program to pay claims when doing so will lower Eligible Expenses. While UnitedHealthcare might negotiate lower Eligible Expenses for Non-Network Benefits, the Coinsurance will stay the same as described in Section 5, *Plan Highlights*.

UnitedHealthcare does not credential the Shared Savings Program providers and the Shared Savings Program providers are not Network providers. Accordingly, in benefit plans that have both Network and non-Network levels of Benefits, Benefits for Covered Health Services provided by Shared Savings Program providers will be paid at the non-Network Benefit level (except in situations when Benefits for Covered Health Services provided by non-Network providers are payable at Network Benefit levels, as in the case of Emergency Health Services). When UnitedHealthcare uses the Shared Savings Program to pay a claim, the patient responsibility is limited to Coinsurance calculated on the contracted rate paid to the provider, in addition to any required Annual Deductible.

Sickness – physical illness, disease or Pregnancy. The term Sickness as used in this SPD does not include Mental Illness or substance use disorder, regardless of the cause or origin of the Mental Illness or substance use disorder.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this SPD includes Mental Illness, or substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness, or substance-related and addictive disorder.

Skilled Care – skilled nursing, teaching, and rehabilitation services when:

- they are delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome and provide for the safety of the patient;
- a Physician orders them;
- they are not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair;
- they require clinical training in order to be delivered safely and effectively; and
- they are not Custodial Care, as defined in this section.

Skilled Nursing Facility – a nursing facility that is licensed and operated as required by law. A Skilled Nursing Facility that is part of a Hospital is considered a Skilled Nursing Facility for purposes of the Plan.

Spouse – an individual to whom you are legally married or a Domestic Partner as defined in this section.

Substance Use Disorder Services – Covered Health Services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded.

Substance Use Disorder Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Total Disability – a Participant's inability to perform all substantial job duties because of physical or mental impairment, or a Dependent's or retired person's inability to perform the normal activities of a person of like age and gender.

Transitional Care – Mental Health Services/Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery; or
- supervised living arrangement which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

UnitedHealth Premium ProgramSM – a program that identifies Network Physicians or facilities that have been designated as a UnitedHealth Premium ProgramSM Physician or facility for certain medical conditions.

To be designated as a UnitedHealth PremiumSM provider, Physicians and facilities must meet program criteria. The fact that a Physician or facility is a Network Physician or facility does not mean that it is a UnitedHealth Premium ProgramSM Physician or facility.

Unproven Services – health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted

randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature:

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies from more than one institution are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

UnitedHealthcare has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, UnitedHealthcare issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment), UnitedHealthcare may, at its discretion, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, UnitedHealthcare must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

The decision about whether such a service can be deemed a Covered Health Service is solely at UnitedHealthcare's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Care – treatment of an unexpected Sickness or Injury that is not life-threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash, or an ear infection.

Urgent Care Center – a facility that provides Urgent Care services, as previously defined in this section. In general, Urgent Care Centers:

- do not require an appointment;
- are open outside of normal business hours, so you can get medical attention for minor illnesses that occur at night or on weekends; and
- provide an alternative if you need immediate medical attention, but your Physician cannot see you right away.

SECTION 15 - PRESCRIPTION DRUGS

What this section includes:

- Benefits available for Prescription Drugs;
- How to utilize the retail and mail order service for obtaining Prescription Drugs;
- Any benefit limitations and exclusions that exist for Prescription Drugs; and
- Definitions of terms used throughout this section related to the Prescription Drug Plan.

Prescription Drug Coverage Highlights

The table below provides an overview of the Plan's Prescription Drug coverage. It includes Copay amounts that apply when you have a prescription filled at a Pharmacy. For detailed descriptions of your Benefits, refer to *Retail* and *Mail Order* in this section.

Note: The Out-of-Pocket Maximum applies to all Covered Health Services under the Plan, including Covered Health Services provided in Section 6, *Additional Coverage Details*.

Covered Health Services ^{1,2}	Percentage of Prescription Drug Charge Payable by the Plan:	Percentage of Predominant Reimbursement Rate Payable by the Plan:
	Network	Non-Network
Retail - up to a 31-day supply	100% after you pay a:	
■ tier-1	\$10 Copay	\$10 Copay
■ tier-2	\$35 Copay	\$35 Copay
■ tier-3	\$70 Copay	\$70 Copay
■ Mail order - up to a 90-day supply		
■ tier-1	\$25 Copay	Not Covered
■ tier-2	\$87.50 Copay	Not Covered
■ tier-3	\$175 Copay	Not Covered

¹You, your Physician or your pharmacist must notify UnitedHealthcare to receive full Benefits for certain Prescription Drugs. Otherwise, you may pay more out-of-pocket. See *Notification Requirements* in this section for details.

²You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

Note: The Coordination of Benefits provision described in Section 10, *Coordination of Benefits (COB)* applies to covered Prescription Drugs as described in this section. Benefits for Prescription Drugs will be coordinated with those of any other health plan in the same manner as Benefits for Covered Health Services described in this SPD.

Identification Card (ID Card) – Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by the Claims Administrator during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug at the pharmacy.

Benefit Levels

Benefits are available for outpatient Prescription Drugs that are considered Covered Health Services.

The Plan pays Benefits at different levels for tier-1, tier-2 and tier-3 Prescription Drugs. All Prescription Drugs covered by the Plan are categorized into these three tiers on the Prescription Drug List (PDL). The tier status of a Prescription Drug can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug, depending on its tier assignment. Since the PDL may change periodically, you can visit www.myuhc.com or call UnitedHealthcare at the toll-free number on your ID card for the most current information.

Each tier is assigned a Copay, which is the amount you pay when you visit the pharmacy or order your medications through mail order. Your Copay will also depend on whether or not you visit the pharmacy or use the mail order service - see the table shown at the beginning of this section for further details. Here's how the tier system works:

- Tier-1 is your lowest Copay option. For the lowest out-of-pocket expense, you should consider tier-1 drugs if you and your Physician decide they are appropriate for your treatment.
- Tier-2 is your middle Copay option. Consider a tier-2 drug if no tier-1 drug is available to treat your condition.
- Tier-3 is your highest Copay option. The drugs in tier-3 are usually more costly. Sometimes there are alternatives available in tier-1 or tier-2.

For Prescription Drugs at a retail Network Pharmacy, you are responsible for paying the lower of:

- the applicable Copay;
- the Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- the Prescription Drug Charge that UnitedHealthcare agreed to pay the Network Pharmacy.

For Prescription Drugs from a mail order Network Pharmacy, you are responsible for paying the lower of:

- the applicable Copay; or
- the Prescription Drug Charge for that particular Prescription Drug.

Retail

The Plan has a Network of participating retail pharmacies, which includes many large drug store chains. You can obtain information about Network Pharmacies by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto www.myuhc.com.

To obtain your prescription from a retail pharmacy, simply present your ID card and pay the Copay. The Plan pays Benefits for certain covered Prescription Drugs:

- as written by a Physician;
- up to a consecutive 31-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits;
- when a Prescription Drug is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copay that applies will reflect the number of days dispensed; and
- a one-cycle supply of an oral contraceptive. You may obtain up to three cycles at one time if you pay a Copay for each cycle supplied.

Note: Pharmacy Benefits apply only if your prescription is for a Covered Health Service, and not for Experimental or Investigational, or Unproven Services. Otherwise, you are responsible for paying 100% of the cost.

Mail Order

The mail order service may allow you to purchase up to a 90-day supply of a covered maintenance drug through the mail. Maintenance drugs help in the treatment of chronic illnesses, such as heart conditions, allergies, high blood pressure, and arthritis.

To use the mail order service, all you need to do is complete a patient profile and enclose your prescription order or refill. Your medication, plus instructions for obtaining refills, will arrive by mail about 14 days after your order is received. If you need a patient profile form,

or if you have any questions, you can reach UnitedHealthcare at the toll-free number on your ID card.

The Plan pays mail order Benefits for certain covered Prescription Drugs:

- as written by a Physician; and
- up to a consecutive 90-day supply, unless adjusted based on the drug manufacturer's packaging size or based on supply limits.

You may be required to fill an initial Prescription Drug order and obtain one refill through a retail pharmacy prior to using a mail order Network Pharmacy.

Note: To maximize your benefit, ask your Physician to write your prescription order or refill for a 90-day supply, with refills when appropriate. You will be charged a mail order Copay for any prescription order or refill if you use the mail order service, regardless of the number of days' supply that is written on the order or refill. Be sure your Physician writes your mail order or refill for a 90-day supply, not a 30-day supply with three refills.

Benefits for Preventive Care Medications

Benefits under the Prescription Drug Plan include those for Preventive Care Medications as defined under *Glossary – Prescription Drugs*. You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Designated Pharmacy

If you require certain Prescription Drugs, UnitedHealthcare may direct you to a Designated Pharmacy with whom it has an arrangement to provide those Prescription Drugs.

Specialty Prescription Drugs

You may fill a prescription for Specialty Prescription Drugs up to two times at any Pharmacy. However, after that you will be directed to a Designated Pharmacy and if you choose not to obtain your Specialty Prescription Drugs from a Designated Pharmacy, no Benefits will be paid and you will be responsible for paying all charges.

Please see the Prescription Drug Glossary in this section for definitions of Specialty Prescription Drug and Designated Pharmacy.

Select Designated Pharmacy

You may fill a prescription for a Select Prescription Drug up to two times at any retail Pharmacy. However, after that you will be directed to a Designated Pharmacy. If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug from a Designated Pharmacy, non-Network Benefits will apply for that Select Prescription Drug.

For more information, visit **myuhc.com** or call UnitedHealthcare at the toll-free number on your ID card.

Please see the Prescription Drug Glossary in this section for the definition of Select Prescription Drug.

Want to lower your out-of-pocket Prescription Drug costs?

Consider tier-1 Prescription Drugs, if you and your Physician decide they are appropriate.

Assigning Prescription Drugs to the PDL

UnitedHealthcare's Prescription Drug List (PDL) Management Committee makes the final approval of Prescription Drug placement in tiers. In its evaluation of each Prescription Drug, the PDL Management Committee takes into account a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include:

- evaluations of the place in therapy;
- relative safety and efficacy; and
- whether supply limits or notification requirements should apply.

Economic factors may include:

- the acquisition cost of the Prescription Drug; and
- available rebates and assessments on the cost effectiveness of the Prescription Drug.

Some Prescription Drugs are most cost effective for specific indications as compared to others, therefore, a Prescription Drug may be listed on multiple tiers according to the indication for which the Prescription Drug was prescribed.

When considering a Prescription Drug for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

The PDL Management Committee may periodically change the placement of a Prescription Drug among the tiers. These changes will not occur more than six times per calendar year and may occur without prior notice to you.

Prescription Drug, Prescription Drug List (PDL), and Prescription Drug List (PDL) Management Committee are defined at the end of this section.

Prescription Drug List (PDL)

The Prescription Drug List (PDL) is a tool that helps guide you and your Physician in choosing the medications that allow the most effective and affordable use of your Prescription Drug benefit.

Prior Authorization Requirements

Before certain Prescription Drugs are dispensed to you, it is the responsibility of your Physician, your pharmacist or you to obtain prior authorization from UnitedHealthcare.

UnitedHealthcare will determine if the Prescription Drug, in accordance with UnitedHealthcare approved guidelines, is both:

- a Covered Health Service as defined by the Plan; and
- not Experimental or Investigational or Unproven, as defined in Section 14, *Glossary*.

The Plan may also require you to obtain prior authorization from UnitedHealthcare so UnitedHealthcare can determine whether the Prescription Drug Product, in accordance with its approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from the Claims Administrator.

Non-Network Pharmacy Prior Authorization

When Prescription Drugs are dispensed at a non-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from the Claims Administrator as required.

If UnitedHealthcare has not provided prior authorization before the Prescription Drug is dispensed, you may pay more for that Prescription Drug order or refill. You will be required to pay for the Prescription Drug at the time of purchase. The contracted pharmacy reimbursement rates (the Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. If UnitedHealthcare has not provided prior authorization before you purchase the Prescription Drug, you can request reimbursement after you receive the Prescription Drug - see Section 9, *Claims Procedures*, for information on how to file a claim.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from the Claims Administrator before the Prescription Drug was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drugs from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drugs from a non-Network Pharmacy), less the required Copayment and/or Coinsurance and any Deductible that applies.

To determine if a Prescription Drug requires prior authorization, either visit **www.myuhc.com** or call the toll-free number on your ID card. The Prescription Drugs requiring prior authorization are subject to UnitedHealthcare's periodic review and modification.

Benefits may not be available for the Prescription Drug after the Claims Administrator reviews the documentation provided and determines that the Prescription Drug is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

UnitedHealthcare may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such

programs through the Internet at **www.myuhc.com** or by calling the toll-free number on your ID card.

Prescription Drug Benefit Claims

For Prescription Drug claims procedures, please refer to Section 9, *Claims Procedures*.

Limitation on Selection of Pharmacies

If the Claims Administrator determines that you may be using Prescription Drugs in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, you may be required to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date the Plan Administrator notifies you, the Claims Administrator will select a single Network Pharmacy for you.

Supply Limits

Some Prescription Drugs are subject to supply limits that may restrict the amount dispensed per prescription order or refill. To determine if a Prescription Drug has been assigned a maximum quantity level for dispensing, either visit **www.myuhc.com** or call the toll-free number on your ID card. Whether or not a Prescription Drug has a supply limit is subject to UnitedHealthcare's periodic review and modification.

Note: Some products are subject to additional supply limits based on criteria that the Plan Administrator and the Claims Administrator have developed, subject to periodic review and modification. The limit may restrict the amount dispensed per prescription order or refill and/or the amount dispensed per month's supply.

If a Brand-name Drug Becomes Available as a Generic

If a Brand-name Prescription Drug becomes available as a Generic drug, the tier placement of the Brand-name Drug may change. As a result, your Copay may change. You will pay the Copay applicable for the tier to which the Prescription Drug is assigned.

Special Programs

Taft Stettinius & Hollister LLP and UnitedHealthcare may have certain programs in which you may receive an enhanced or reduced benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at **www.myuhc.com** or by calling the number on the back of your ID card.

Maintenance Medication Program

If you require certain Maintenance Medications, UnitedHealthcare may direct you to the Mail Order Network Pharmacy to obtain those Maintenance Medications.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced benefit, or no benefit, based on whether the Prescription Drug was prescribed by a specialist physician. You may access information on which Prescription Drugs are subject to benefit enhancement, reduction or no benefit through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

Step Therapy

Certain Prescription Drugs for which Benefits are described in this section or Pharmaceutical Products for which Benefits are described under your medical Benefits are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drugs and/or Pharmaceutical Products you are required to use a different Prescription Drug(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug or Pharmaceutical Product is subject to step therapy requirements by visiting **www.myuhc.com** or by calling the number on the back of your ID card.

Rebates and Other Discounts

UnitedHealthcare and Taft Stettinius & Hollister LLP may, at times, receive rebates for certain drugs on the PDL. UnitedHealthcare does not pass these rebates and other discounts on to you nor does UnitedHealthcare take them into account when determining your Copays.

The Claims Administrator and a number of its affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this Prescription Drug section. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this Prescription Drug section. The Claims Administrator is not required to pass on to you, and does not pass on to you, such amounts.

Coupons, Incentives and Other Communications

UnitedHealthcare may send mailings to you or your Physician that communicate a variety of messages, including information about Prescription Drugs. These mailings may contain coupons or offers from pharmaceutical manufacturers that allow you to purchase the described Prescription Drug at a discount or to obtain it at no charge. Pharmaceutical manufacturers may pay for and/or provide the content for these mailings. Only your Physician can determine whether a change in your Prescription order or refill is appropriate for your medical condition.

UnitedHealthcare may not permit certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance. You may access information on which coupons or offers are not permitted through the Internet at **www.myuhc.com** or by calling the number on your ID card.

Exclusions - What the Prescription Drug Plan Will Not Cover

Exclusions from coverage listed in Section 8, *Exclusions* apply also to this section. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drugs, you can access **www.myuhc.com** through the Internet or by calling the telephone number on your ID card for information on which Prescription Drugs are excluded.

Medications that are:

1. for any condition, Injury, Sickness or mental illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received;
2. any Prescription Drug for which payment or benefits are provided or available from the local, state or federal government (for example Medicare) whether or not payment or benefits are received, except as otherwise provided by law;
3. Pharmaceutical Products for which Benefits are provided in the medical (not in Section 15, *Prescription Drugs*) portion of the Plan;

This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.

4. available over-the-counter that do not require a prescription order or refill by federal or state law before being dispensed, unless the Plan Administrator has designated over-the-counter medication as eligible for coverage as if it were a Prescription Drug and it is obtained with a prescription order or refill from a Physician. Prescription Drugs that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drugs that the Plan Administrator has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Plan Administrator may decide at any time to reinstate Benefits for a Prescription Drug that was previously excluded under this provision;
5. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a prescription order or refill. Compounded drugs that are available as a similar commercially available Prescription Drug. (Compounded drugs that contain at least one ingredient that requires a prescription order or refill are assigned to Tier-3;
6. dispensed outside of the United States, except in an Emergency;
7. Durable Medical Equipment (prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered);
8. growth hormone for children with familial short stature based upon heredity and not caused by a diagnosed medical condition;

9. the amount dispensed (days' supply or quantity limit) which exceeds the supply limit;
10. the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit;
11. certain Prescription Drugs that have not been prescribed by a specialist physician;
12. certain new drugs and/or new dosages, until they are reviewed and assigned to a tier by the PDL Management Committee;
13. prescribed, dispensed or intended for use during an Inpatient Stay;
14. prescribed for appetite suppression, and other weight loss products;
15. prescribed to treat infertility;
16. Prescription Drugs, including new Prescription Drugs or new dosage forms, that UnitedHealthcare and Taft Stettinius & Hollister LLP determines do not meet the definition of a Covered Health Service;
17. Prescription Drugs that contain (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug;
18. Prescription Drugs that contain (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug;
19. typically administered by a qualified provider or licensed health professional in an outpatient setting. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception;
20. unit dose packaging of Prescription Drugs;
21. used for conditions and/or at dosages determined to be Experimental or Investigational, or Unproven, unless UnitedHealthcare and Taft Stettinius & Hollister LLP have agreed to cover an Experimental or Investigational or Unproven treatment, as defined in Section 14, *Glossary*;
22. used for cosmetic purposes;
23. Prescription Drug as a replacement for a previously dispensed Prescription Drug that was lost, stolen, broken or destroyed; and
24. vitamins, except for the following which require a prescription:
 - prenatal vitamins;
 - vitamins with fluoride; and
 - single entity vitamins.

Glossary - Prescription Drugs

Brand-name - a Prescription Drug that is either:

- manufactured and marketed under a trademark or name by a specific drug manufacturer; or
- identified by UnitedHealthcare as a Brand-name Drug based on available data resources including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by the Claims Administrator.

Copayment (or Copay) – the set dollar amount you are required to pay for certain Prescription Drugs.

Designated Pharmacy – a pharmacy that has entered into an agreement with UnitedHealthcare or with an organization contracting on its behalf, to provide specific Prescription Drugs including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Generic - a Prescription Drug that is either:

- chemically equivalent to a Brand-name drug; or
- identified by UnitedHealthcare as a Generic Drug based on available data resources, including, but not limited to, Medi-Span, that classify drugs as either Brand-name or Generic based on a number of factors.

You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by the Claims Administrator.

Maintenance Medication – a Prescription Drug Product anticipated to be used for six months or more to treat or prevent a chronic condition. You may determine whether a Prescription Drug Product is a Maintenance Medication through the Internet at www.myuhc.com or by calling the telephone number on your ID card.

Network Pharmacy - a retail or mail order pharmacy that has:

- entered into an agreement with the Claims Administrator to dispense Prescription Drugs to Covered Persons;
- agreed to accept specified reimbursement rates for Prescription Drugs; and
- been designated by the Claims Administrator as a Network Pharmacy.

PDL - see Prescription Drug List (PDL).

PDL Management Committee - see Prescription Drug List (PDL) Management Committee.

Predominant Reimbursement Rate – the amount the Plan will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. The Claims Administrator calculates the Predominant Reimbursement Rate using its Prescription Drug Charge that applies for that particular Prescription Drug at most Network Pharmacies.

Prescription Drug - a medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, only be dispensed using a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For purposes of this Plan, Prescription Drugs include:

- inhalers (with spacers);
- insulin;
- the following diabetic supplies:
 - insulin syringes with needles;
 - blood testing strips - glucose;
 - urine testing strips - glucose;
 - ketone testing strips and tablets;
 - lancets and lancet devices;
 - insulin pump supplies, including infusion sets, reservoirs, glass cartridges, and insertion sets; and
 - glucose monitors.

Prescription Drug Charge – the rate UnitedHealthcare has agreed to pay its Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug dispensed at a Network Pharmacy.

Prescription Drug List (PDL) - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration*. This list is subject to periodic review and modification (generally quarterly, but no more than six times per calendar year). You may determine to which tier a particular Prescription Drug has been assigned by contacting UnitedHealthcare at the toll-free number on your ID card or by logging onto www.myuhc.com.

Prescription Drug List (PDL) Management Committee - the committee that UnitedHealthcare designates for, among other responsibilities, classifying Prescription Drugs into specific tiers.

Preventive Care Medications - the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible, Annual

Prescription Drug Deductible or Specialty Prescription Drug Annual Deductible) as required by applicable law under any of the following:

- evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- with respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; or
- with respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling UnitedHealthcare at the toll-free telephone number on your ID card.

Select Prescription Drug - a Prescription Drug that is generally a tier-3 drug with lower-tiered alternatives used to treat the same condition. For more information, visit myuhc.com or call UnitedHealthcare at the toll-free number on your ID card.

Specialty Prescription Drug - Prescription Drug that is generally high cost, self-injectable, oral or inhaled biotechnology drug used to treat patients with certain illnesses. For more information, visit myuhc.com or call UnitedHealthcare at the toll-free number on your ID card.

Therapeutically Equivalent – when Prescription Drugs have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge – the usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

SECTION 16 - HEALTH REIMBURSEMENT ACCOUNT PLAN - NUMBER HRA NO. 729531

This Section describes the healthcare expense reimbursement component of the Plan. It includes summaries of:

- What is a Health Reimbursement Account (HRA) Plan; Who is Eligible and How to Enroll; and How the HRA Plan Works;
- New Hires And Adjustments For Status Changes;
- What Type of Expenses Qualify for Reimbursement from the HRA;
- What Happens to Remaining Balances in your HRA;
- HRA Claims Procedures; and
- HRA Administrative Information.

Notice to Employees

This Section of the Summary Plan Description (SPD) describes the Employer-sponsored Health Reimbursement Account (HRA) Plan.

Taft Stettinius & Hollister LLP has entered into an agreement with United HealthCare Services, Inc., Hartford, CT ("UnitedHealthcare") under which UnitedHealthcare will process eligible healthcare expense reimbursements through the HRA and provide certain other administrative services pertaining to the Plan. UnitedHealthcare does not insure the benefits described in this Section.

Quick Reference Box

- Member services and claim inquiries, use the Customer Service number on the back of your ID card or call 1-800-331-0480;
- HRA Claims submittal address: Health Care Account Service Center, PO Box 981506, El Paso, TX 79998-1506; and
- Online assistance: www.myuhc.com.

Welcome - HRA

This Section of your Summary Plan Description (SPD) describes the Health Reimbursement Account (HRA) available to you and your eligible dependents enrolled in the Plan.

A Health Reimbursement Account is a financial account that allows Taft Stettinius & Hollister LLP to reimburse you for "qualified" health expenses paid by you, under the associated medical plan, to offset health care costs.

The HRA maximizes the value of your health care dollars, and allows you to become more engaged in managing health care spending. We offer several tools to help you make more

informed health care decisions and manage your HRA account balance; refer to Section 6 - *Resources to Help You Stay Healthy* for information on health and well-being resources available to you, or visit www.myuhc.com for access to a treatment cost estimator. Once you spend your entire HRA balance, you are responsible for paying expenses as described in your SPD.

You can keep track of the funds in your HRA by going online to www.myuhc.com, by calling the toll-free number on the back of your ID card or by checking your monthly member statement sent to you by UnitedHealthcare.

Please read this Section thoroughly to learn how the HRA component of the Plan works. If you have questions call the number on the back of your ID card. Capitalized terms not otherwise defined in this Section have the meaning set forth in the SPD, Section 13 - *Glossary*.

What is a Health Reimbursement Account?

Health Reimbursement Accounts are "unfunded" accounts; otherwise known as a demand deposit account. The Taft Stettinius & Hollister LLP is not required to prepay into it, instead, funds allocated to the HRA are made available to reimburse you for claims as they occur. All contributions allocated to your HRA are owned, controlled and payable solely from the general assets of Taft Stettinius & Hollister LLP. You are not permitted to make any contribution to the HRA, whether made on a pre-tax or after-tax basis. In addition:

- The HRA is established by Taft Stettinius & Hollister LLP and administered by UnitedHealthcare in accordance with applicable provisions of the Internal Revenue Service Code and associated guidance issued by the IRS/Treasury Department.
- Taft Stettinius & Hollister LLP determines which Internal Revenue Code 213d health expenses will be eligible for reimbursement through the HRA.
- Reimbursements of qualified medical expenses are tax-deductible for Taft Stettinius & Hollister LLP.
- There is no limit to the contributions Taft Stettinius & Hollister LLP can choose to allocate to your account.
- Employer contributions allocated to your HRA can be excluded from your gross income.
- Taft Stettinius & Hollister LLP will decide how to handle unused funds at the end of the plan year. Unused funds are not transferable if your employment with Taft Stettinius & Hollister LLP ends.

Introduction - HRA

Who Is Eligible for the HRA And How To Enroll

You must be covered under a medical plan sponsored by Taft Stettinius & Hollister LLP and administered by UnitedHealthcare in order to participate in the HRA. You are enrolled in the HRA at the same time you enroll in your medical plan. You cannot elect it separately and you can't withdraw from it unless you also withdraw from the medical plan. Eligibility to

participate in the Plan is described in this SPD, Section 2 - *Introduction*. Contact Human Resources if you have questions about eligibility and enrollment.

Each year during annual Open Enrollment, you have the opportunity to review and change your benefit election. Any changes you make during Open Enrollment will become effective as described in this SPD, Section 2 - *Introduction*.

Important

If you wish to change your benefit elections following a marriage, birth, adoption of a child, placement for adoption of a child or other family status change, you must contact Human Resources as described in this SPD, Section 2 - *Introduction* under the heading *Changing Your Coverage*. Otherwise, you will need to wait until the next annual Open Enrollment to change your elections.

Cost of Coverage

You and Taft Stettinius & Hollister LLP share in the cost of the medical plan, there is no charge to you for participation in the financial account component of your Plan. Your contribution amount, (also known as a premium) depends on the medical plan you select and the family members you choose to enroll.

Your medical plan premium is deducted from your paychecks on a before-tax basis. Before-tax dollars come out of your pay before federal income and Social Security taxes are withheld - and in most states, before state and local taxes are withheld. For more information on the Cost of Coverage please refer to Section 2 - *Introduction* under the heading *Cost of Coverage*.

Changing Your HRA Coverage

If you are hired during the Plan year or are enrolling in the Plan mid-year during a special enrollment period, coverage will become effective as described in Section 2 - *Introduction* under the heading *Changing Your Coverage*.

For detail on the employer contribution to your HRA for mid-year enrollment and/or status changes see this Section under the heading *How the HRA Works*, and look for "New Hires and Adjustments for Status Changes".

For information on ending your coverage please refer to this Section under the heading *When HRA Coverage Ends*.

How The HRA Works**How much money is allocated to your HRA – Employer Contributions**

Taft Stettinius & Hollister LLP will allocate a specified amount of funds to your HRA on a plan year basis specific to the coverage category you enroll in. For each claim presented to the HRA, available funds will be used to pay for your HRA Eligible Expenses. The table below contains the details for the employer contribution to your HRA:

Coverage Category	Annually Employer Contribution to your HRA ¹
■ individual	\$750
■ family	\$1,500

¹This is the only amount that will be placed in your HRA during the plan year and may be used for HRA Eligible Expenses.

New Hires And Adjustments For Status Changes

Mid-Year Enrollment

If you are hired during the Plan year or are enrolling in the Plan mid-year during a special enrollment period as a result of a change in status, the amount of the Employer contribution allocated to your HRA will be prorated on a monthly basis effective the first day of the month following the month in which you are enrolled in the Plan.

Status Changes

When you switch among coverage categories the Taft Stettinius & Hollister LLP's contribution amount allocated to your HRA may increase or decrease by category.

Under the Plan, if you increase your category (e.g. individual to family) the Employer contribution to your HRA is adjusted to your new category for that Plan year minus any amounts already accumulated or used in that Plan year. Any funds in your HRA that had rolled over from previous Plan years will remain with you.

If you decrease your category (e.g. you change from family to individual) the Employer contribution to your HRA is adjusted to your new category for that Plan year minus any amounts already accumulated or used in that Plan year. The amount in your HRA can not have a negative balance. Any funds in your HRA that had rolled over from previous Plan years will remain with you.

Reinstatement without a break in coverage. Following a termination, if you are rehired by Taft Stettinius & Hollister LLP, can you be reinstated without experiencing any break in coverage?

Yes, your HRA Plan does allow for reinstatement as if no break in coverage occurred. When you are rehired by Taft Stettinius & Hollister LLP within 30 days following your employment termination date and re-enroll in the active medical plan and the HRA Plan the HRA Contribution amount will equal the balance you held in your HRA on the day prior to your employment termination date.

Reinstatement with a break in coverage. Are you able to recover funds after a break in employment?

No, you cannot use prior accumulated balances after re-enrollment as a result of a break in employment. When you are rehired by Taft Stettinius & Hollister LLP and re-enroll in the active medical plan and the HRA Plan the HRA Contribution amount will equal the amount a newly hired active employee would be eligible for. (See this Section under the heading *Mid-Year Enrollment*.)

You can keep track of the funds in your HRA by going online to www.myuhc.com, by calling the toll-free number on the back of your ID card or by checking your monthly member statement sent to you by UnitedHealthcare.

What Type of Medical Expenses Qualify for Reimbursement From The HRA

Not all health-related expenses qualify for reimbursement under the HRA Plan. Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time defines what health care expenses are considered "qualified" medical expenses for federal income tax purposes. Only amounts that are paid specifically to reimburse eligible medical care expenses, as defined in Section 213(d), will be covered under the HRA Plan. Your Employer has determined which of those "qualified" medical expenses will be considered HRA Eligible Expenses under your Plan and reimbursable from your HRA.

What Happens To Remaining Balances In Your HRA

If you don't spend all the funds in your HRA during the initial plan year, and you re-enroll in the Plan for the following year, a portion of your remaining HRA balance rolls over into your account for the next plan year. In this manner your HRA may "grow" almost like a savings account.

If you don't re-enroll in the Plan for the following year, you forfeit any unused funds remaining in the account.

HRA Rollover Maximum

The maximum amount that can be rolled over is limited as follows:

Coverage Category	HRA Rollover Maximum per plan year
■ individual	\$2,250
■ family	\$4,500

HRA Claim Procedures

What this section includes:

- How HRA claims payments work;
- Requesting Reimbursement from Your HRA; and
- What to do if your claim is denied, in whole or in part.

Claims Submission

Taft Stettinius & Hollister LLP has designed your HRA to allow certain claims to be automatically submitted to your account for reimbursement. UnitedHealthcare will coordinate payments from your HRA for medical claims only. You can turn this feature "off" or back "on" via myuhc.com.

There are some types of claims that will not be processed automatically for which you will need to submit a claim manually; for additional information on these claims see the header below called *When to Submit a Claim*.

When auto-submission is elected all reimbursements from the HRA will be sent directly to the provider, exceptions are listed below. When no provider information is available the reimbursement will be sent to you. In the 3 exception situations listed below, the reimbursement from the HRA will go directly to you and not the provider:

- Manually submitted claims (paper claims you submit directly).
- Non-Network provider claims.
- Claims adjustments.

Network Benefits

In general, if you receive Covered Health Services from a Network provider, UnitedHealthcare will process the payment for the medical plans portion of the cost of the Covered Health Services and send it directly to the Physician or facility.

Funds allocated to your HRA will be available to help you pay a portion of your out-of-pocket costs under the medical plan as described in this SPD in Section 3 - *How the Plan Works*. UnitedHealthcare will process the payment for a portion of your cost of the Covered Health Services from available funds in your HRA and send it directly to the Physician or facility automatically. This feature can be turned on and off by accessing myuhc.com. There are some types of claims that will not be paid directly to the provider, they are as follows: manually submitted claims and adjustments and out of network provider claims. These types of claims will always pay you directly.

Non-Network Benefits

If you receive a bill for Covered Health Services from a non-Network provider, you (or the provider if they prefer) must send the bill to UnitedHealthcare for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare at the address on the back of your ID card.

If you receive Covered Health Services from a non-Network provider funds from your HRA will automatically be reimbursed to you, up to the amount available in your HRA. You will only be reimbursed from your HRA for expenses incurred while you are a Covered Person under the Plan.

When to Submit a Claim

There are some types of claims that will not be processed automatically for which you will need to submit a claim. When Auto-rollover feature does not apply, you must submit a claim for reimbursement from your HRA including any other types of expenses other than Covered Health Services and any health expenses not submitted to UnitedHealthcare.

If you receive a bill for Covered Health Services from a provider, you must send the bill to UnitedHealthcare for processing.

Important - Timely Filing of Non-Network Claims

All claim forms must be submitted within 12 months after the date of service. Otherwise, the Plan will not pay any Benefits for that Eligible Expense, or Benefits will be reduced, as determined by UnitedHealthcare. This 12-month requirement does not apply if you are legally incapacitated.

How to File Your Claim for Reimbursement from the HRA

To be reimbursed from your HRA simply submit a reimbursement form, called a Request for Withdrawal Form, for the HRA Eligible Expenses that have been incurred. A Request for Withdrawal Form is available from Taft Stettinius & Hollister LLP or on the Internet at **www.myuhc.com**. For reimbursement from your HRA, you must include proof of the expenses incurred as indicated on the Request for Withdrawal Form. For HRA Eligible Expenses, proof can include a bill, invoice, or an Explanation of Benefits (EOB) from your group medical plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical plans.

To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to UnitedHealthcare HRA Claims submittal address:

Health Care Account Service Center
PO Box 981506
El Paso, TX 79998-1506

Important

You can view EOB's and Health Statements online via **myuhc.com**.

Myuhc.com includes many features such as the option to:

- View your HRA summary page detailing contributions and amount left in your HRA;
- View your HRA Claims Summary including claim transaction details.

Health Statements

Each month that UnitedHealthcare processes at least one claim for you or a covered Dependent, you will receive a Health Statement in the mail. Health Statements make it easy for you to manage your family's medical costs by providing claims information in easy-to-understand terms.

If you would rather track claims for yourself and your covered Dependents online, you may do so at www.myuhc.com. You may also elect to discontinue receipt of paper Health Statements by making the appropriate selection on this site.

Explanation of Benefits (EOB)

You may request that UnitedHealthcare send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free number on your ID card to request them. You can also view and print all of your EOBs online at myuhc.com. See Section 13, *Glossary* for the definition of Explanation of Benefits.

Requesting Reimbursement from Your HRA

If you have allocated funds available in your HRA you may submit a claim for reimbursement for the HRA Eligible Expenses from your HRA. If you submit a request for reimbursement for Network claims, the request must be received no later than 90 days following the end of the plan year in which you are eligible under this Plan. All claim forms for non-Network claims must be submitted within 365 days of the date of service. If you don't provide this information to the Claims Administrator within this timeframe, your claim will not be eligible for reimbursement, even if there are funds available in your HRA. This time limit does not apply if you are legally incapacitated.

You cannot be reimbursed for any expense paid under your medical plan, and any expenses for which you are reimbursed from your HRA cannot be included as a deduction or credit on your federal income tax return.

Important Note

- The date on which you incurred an eligible medical expense is used when deducting amounts from your HRA. This allows your HRA to act like a savings account, available for your use when your claim is paid.

Claim Denials and Appeals**If Your Claim is Denied**

If a claim for Benefits is denied in part or in whole, you may call UnitedHealthcare at the number provided by Taft Stettinius & Hollister LLP before requesting a formal appeal. If UnitedHealthcare cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you or your authorized representative must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;
- the provider's name;
- the date of medical service or expense;
- the reason you disagree with the denial; and
- any documentation or other written information to support your request.

If you wish to request a formal appeal of a denied claim for reimbursement, you should call the number provided by Taft Stettinius & Hollister LLP to obtain the UnitedHealthcare address where the appeal should be sent. For Urgent Care claims that have been denied, you or your provider can call UnitedHealthcare at the toll-free number on your ID card to request an appeal.

Appeals for your HRA should be submitted to:

UnitedHealthcare – HRA Group Claims
P.O. Box 981178
El Paso, TX 79998-1178

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from UnitedHealthcare within 60 days from receipt of the first level appeal. UnitedHealthcare must notify you of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments.

UnitedHealthcare will review all claims in accordance with the rules established by the U.S. Department of Labor. UnitedHealthcare's decision will be final.

For additional information on claims procedures and appeals, including the time frames which you and UnitedHealthcare are required to follow, please refer to Section 8, *Claims Procedures*.

HRA Coordination of Benefits (COB) And Subrogation And Reimbursement

For information on how your Benefits under this Plan coordinate with other medical plans and how coverage is affected if you become eligible for Medicare, refer to Section 10 - *Coordination of Benefits*.

Overpayment and Underpayment of Benefits

Coordination of Benefits (COB) applies to you if you are covered by more than one health benefits plan. For further information on COB refer to Section 10 - *Coordination of Benefits*.

Subrogation and Reimbursement

The Plan has a right to subrogation and reimbursement, as defined in Section 11 - *Subrogation and Reimbursement*.

When HRA Coverage Ends

Your coverage under the Plan ends as described in Section 11 - *When Coverage Ends*.

Continuation of Coverage - Consolidated Omnibus Budget Reconciliation Act ("COBRA")

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Health Reimbursement Account. You should call Taft Stettinius & Hollister LLP to find out whether this Plan is subject to COBRA. If the Plan is subject to COBRA see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)".

COBRA continuation coverage must be offered with respect to a participant's HRA when the Plan is subject to COBRA. If your employment terminates for any reason the funds in your HRA will revert back to us after your claim run-out period, unless you elect COBRA coverage as described in Section 11 - *When Coverage Ends* under the heading *Changing Your Coverage*. If you elect COBRA coverage, HRA funds will remain available to assist you in paying your out-of-pocket costs under the medical plan while COBRA coverage is in effect. The HRA balances under COBRA are recalculated using the methods elected by Taft Stettinius & Hollister LLP for mid-year enrollment and/or status changes; as described in this Section under the heading *How the HRA Works*, and look for *New Hires and Adjustments for Status Changes*.

HRA Glossary

Many of the terms used throughout this Section may be unfamiliar to you or have a specific meaning with regard to the way the Plan is administered and how benefits are paid. The HRA Glossary defines terms used throughout this Section, but it does not describe the benefits provided by the Plan. Capitalized terms not otherwise defined in this section have the meaning set forth in your medical plan SPD.

HRA - Health Reimbursement Account or HRA. It is an IRS Section 105 and 106 account that follows standard regulations and tax benefits for such accounts. It can only be used for qualified medical expenses.

HRA Eligible Expense - an expense that you incur specific to health care on or after the date you are enrolled in the HRA Plan and include the following: (i) an eligible medical expense as defined in Section 213(d); (ii) an Eligible Expense as defined in your medical plan SPD ; (iii) a medical expense not paid for under your active medical Plan as it represents your portion of responsibility for the cost of health care such as Annual Deductible; and (iv) a medical expense not reimbursable through any other plan covering health benefits, other insurance, or any other accident or health plan.

HRA Plan - The Health Reimbursement Account portion of the Taft Stettinius & Hollister LLP Welfare Benefit Plan.

HRA Administrative Information: ERISA

What this Section includes:

- Plan administrative information, including your rights under ERISA.

This Section includes information on the administration of the HRA portion of the Plan as well as information required of all Summary Plan Descriptions by ERISA. Information on the medical portion of the Plan can be found in this SPD, Section 17, Important Administrative Information: ERISA.

Plan Sponsor and Administrator

Taft Stettinius & Hollister LLP is the Plan Sponsor and Plan Administrator of the HRA portion of the Taft Stettinius & Hollister LLP Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – HRA Plan
Taft Stettinius & Hollister LLP
425 Walnut Street
Suite 1800
Cincinnati, OH 45202-3957
(513) 381-2838

Claims Administrator - HRA

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process - HRA Plan

Taft Stettinius & Hollister LLP
425 Walnut Street
Suite 1800
Cincinnati, OH 45202-3957
(513) 381-2838

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This Section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Taft Stettinius & Hollister LLP Welfare Benefit Plan
Plan Number:	501
Employer ID:	31-0541755
Plan Type:	Welfare benefits plan
Plan year:	June 1 – May 31
Plan Administration:	Self-Insured

TAFT STETTINIUS & HOLLISTER LLP MEDICAL CHOICE PLUS HRA PLAN

Source of Plan Contributions:	Company
Source of Benefits:	Assets of the Company

SECTION 17 - IMPORTANT ADMINISTRATIVE INFORMATION: ERISA**What this section includes:**

- Plan administrative information, including your rights under ERISA.

This section includes information on the administration of the medical Plan, as well as information required of all Summary Plan Descriptions by ERISA as defined in Section 14, *Glossary*. While you may not need this information for your day-to-day participation, it is information you may find important.

Plan Sponsor and Administrator

Taft Stettinius & Hollister LLP is the Plan Sponsor and Plan Administrator of the Taft Stettinius & Hollister LLP Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – Medical Plan
Taft Stettinius & Hollister LLP
425 Walnut Street
Suite 1800
Cincinnati, OH 45202-3957
(513) 381-2838

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United HealthCare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process – Medical Plan
Taft Stettinius & Hollister LLP
425 Walnut Street
Suite 1800

Cincinnati, OH 45202-3957
(513) 381-2838

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	Taft Stettinius & Hollister LLP Welfare Benefit Plan
Plan Number:	501
Employer ID:	31-0541755
Plan Type:	Welfare benefits plan
Plan Year:	June 1 – May 31
Plan Administration:	Self-Insured
Source of Plan Contributions:	Employee and Company
Source of Benefits:	Assets of the Company

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all plan documents – including pertinent insurance contracts, collective bargaining agreements (if applicable), and other documents available at the Public Disclosure Room of the Employee Benefits Security Administration; and
- obtain copies of all Plan documents and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the Plan documents to understand the rules governing your COBRA continuation coverage rights.

You will be provided a Certificate of Creditable Coverage in writing, free of charge, from UnitedHealthcare:

when you lose coverage under the Plan;

when you become entitled to elect COBRA;

when your COBRA coverage ends;

if you request a Certificate of Creditable Coverage before losing coverage; or

if you request a Certificate of Creditable Coverage up to 24 months after losing coverage.

You may request a Certificate of Creditable Coverage by calling the toll free number on your ID card.

If you have creditable coverage from another group health plan, you may receive a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan. Without evidence of creditable coverage, Plan Benefits for the treatment of a preexisting condition may be excluded for 12 months (18 months for late enrollees) after your enrollment date in your coverage. In addition to creating rights for Plan

participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. See Section 9, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document from the Plan, and do not receive it within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent for reasons beyond the control of the Plan Administrator.

If you have a claim for Benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

The Plan's Benefits are administered by Taft Stettinius & Hollister LLP, the Plan Administrator. UnitedHealthcare is the Claims Administrator and processes claims for the Plan and provides appeal services; however, UnitedHealthcare and Taft Stettinius & Hollister LLP are not responsible for any decision you or your Dependents make to receive treatment, services or supplies, whether provided by a Network or non-Network provider. UnitedHealthcare and Taft Stettinius & Hollister LLP are neither liable nor responsible for the treatment, services or supplies provided by Network or non-Network providers.

ATTACHMENT I - HEALTH CARE REFORM NOTICES

Patient Protection and Affordable Care Act ("PPACA")

Patient Protection Notices

The Claims Administrator generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator at the number on the back of your ID card.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the Claims Administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claims Administrator at the number on the back of your ID card.

ATTACHMENT II – LEGAL NOTICES

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, we provide Benefits under the Plan for mastectomy, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

If you are receiving Benefits in connection with a mastectomy, Benefits are also provided for the following Covered Health Services, as you determine appropriate with your attending Physician:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The amount you must pay for such Covered Health Services (including Copayments and any Annual Deductible) are the same as are required for any other Covered Health Service. Limitations on Benefits are the same as for any other Covered Health Service.

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under Federal law, group health Plans and health insurance issuers offering group health insurance coverage generally may not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under Federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your issuer.

ADDENDUM - UNITEDHEALTH ALLIES

Introduction

This Addendum to the Summary Plan Description provides discounts for select non-Covered Health Services from Physicians and health care professionals.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:

UnitedHealth Allies is not a health insurance plan. You are responsible for the full cost of any services purchased, minus the applicable discount. Always use your health insurance plan for Covered Health Services described in the Summary Plan Description (see Section 5, *Plan Highlights*) when a benefit is available.

What is UnitedHealth Allies?

UnitedHealth Allies is a health value program that offers savings on certain products and services that are not Covered Health Services under your health plan.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through UnitedHealth Allies are available to you and your Dependents as defined in the Summary Plan Description in Section 14, *Glossary*.

Selecting a Discounted Product or Service

A list of available discounted products or services can be viewed online at **www.healthallies.com** or by calling the number on the back of your ID card.

After selecting a health care professional and product or service, reserve the preferred rate and print the rate confirmation letter. If you have reserved a product or service with a customer service representative, the rate confirmation letter will be faxed or mailed to you.

Important:

You must present the rate confirmation at the time of receiving the product or service in order to receive the discount.

Visiting Your Selected Health Care Professional

After reserving a preferred rate, make an appointment directly with the health care professional. Your appointment must be within ninety (90) days of the date on your rate confirmation letter.

Present the rate confirmation and your ID card at the time you receive the service. You will be required to pay the preferred rate directly to the health care professional at the time the service is received.

Additional UnitedHealth Allies Information

Additional information on the UnitedHealth Allies program can be obtained online at **www.healthallies.com** or by calling the toll-free phone number on the back of your ID card.

ADDENDUM - PARENTSTEPS®

Introduction

This Addendum to the Summary Plan Description illustrates the benefits you may be eligible for under the ParentSteps program.

When the words "you" and "your" are used the Plan is referring to people who are Covered Persons as the term is defined in the Summary Plan Description (SPD). See Section 14, *Glossary* in the SPD.

Important:

ParentSteps is not a health insurance plan. You are responsible for the full cost of any services purchased. ParentSteps will collect the provider payment from you online via the ParentSteps website and forward the payment to the provider on your behalf. Always use your health insurance plan for Covered Health Services (described in the Summary Plan Description Section 5, *Plan Highlights*) when a benefit is available.

What is ParentSteps?

ParentSteps is a discount program that offers savings on certain medications and services for the treatment of infertility that are not Covered Health Services under your health plan.

This program also offers:

- guidance to help you make informed decisions on where to receive care;
- education and support resources through experienced infertility nurses;
- access to providers contracted with UnitedHealthcare that offer discounts for infertility medical services; and
- discounts on select medications when filled through a designated pharmacy partner.

Because this is not a health insurance plan, you are not required to receive a referral or submit any claim forms.

Discounts through this program are available to you and your Dependents. Dependents are defined in the Summary Plan Description in Section 14, *Glossary*.

Registering for ParentSteps

Prior to obtaining discounts on infertility medical treatment or speaking with an infertility nurse you need to register for the program online at www.myoptumhealthparentsteps.com or by calling ParentSteps toll-free at 1-877-801-3507.

Selecting a Contracted Provider

After registering for the program you can view ParentSteps facilities and clinics online based on location, compare IVF cycle outcome data for each participating provider and see the

specific rates negotiated by ParentSteps with each provider for select types of infertility treatment in order to make an informed decision.

Visiting Your Selected Health Care Professional

Once you have selected a provider, you will be asked to choose that clinic for a consultation. You should then call and make an appointment with that clinic and mention you are a ParentSteps member. ParentSteps will validate your choice and send a validation email to you and the clinic.

Obtaining a Discount

If you and your provider choose a treatment in which ParentSteps discounts apply, the provider will enter in your proposed course of treatment. ParentSteps will alert you, via email, that treatment has been assigned. Once you log in to the ParentSteps website, you will see your treatment plan with a cost breakdown for your review.

After reviewing the treatment plan and determining it is correct you can pay for the treatment online. Once this payment has been made successfully ParentSteps will notify your provider with a statement saying that treatments may begin.

Speaking with a Nurse

Once you have successfully registered for the ParentSteps program you may receive additional educational and support resources through an experienced infertility nurse. You may even work with a single nurse throughout your treatment if you choose.

For questions about diagnosis, treatment options, your plan of care or general support, please contact a ParentSteps nurse via phone (toll-free) by calling 1-866-774-4626.

ParentSteps nurses are available from 8 a.m. to 5 p.m. Central Time; Monday through Friday, excluding holidays.

Additional ParentSteps Information

Additional information on the ParentSteps program can be obtained online at www.myoptumhealthparentsteps.com or by calling 1-877-801-3507 (toll-free)

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EXHIBIT F

All Savers Insurance Company

Compass Plus Individual Medical Policy

Agreement and Consideration

We will pay Benefits as set forth in this Policy. This Policy is issued in exchange for and on the basis of the statements made on your application and payment of the first Premium. It takes effect on the effective date shown above. Coverage will remain in force until the first Premium due date, and for such further periods for which Premium payment is received by us when due, subject to the renewal provision below. Coverage will begin at 12:01 a.m. and end at 12:00 midnight in the time zone where you live.

Guaranteed Renewable Subject to Listed Conditions

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent coverage you have with us. This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if we refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, or there is fraud or a material misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits.

On January 1 of each calendar year, we may change the rate table used for this Policy form. Each Premium will be based on the rate table in effect on that Premium's due date. Some of the factors used in determining your Premium rates are the Policy plan, tobacco use status of Covered Persons, type and level of Benefits and place of residence on the Premium due date and age of Covered Persons as of the effective date or renewal date of coverage. Premium rates are expected to increase over time.

At least 90 days' notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records.

10-Day Right to Examine and Return this Policy

Please read this Policy. If you are not satisfied, you may notify us within 10 days after you received it. Any Premium paid will be refunded, less claims paid. This Policy will then be void from its start.

This Policy is signed for us as of the effective date as shown above.

Patrick F. Carr



This Policy

This Policy is a legal document between All Savers Insurance Company and you to provide Benefits to Covered Persons, subject to the terms, conditions, exclusions and limitations of this Policy. We issue this Policy based on the Policyholder's application and payment of the required Premium.

This Policy includes:

- The *Schedule of Benefits*.
- The Policyholder's application.
- Riders, including the Outpatient Prescription Drug Rider, the Pediatric Vision Care Services Rider and the Pediatric Dental Rider.
- Amendments.

Changes to the Document

We may from time to time modify this Policy by attaching legal documents called Riders and/or Amendments that may change certain provisions of this Policy. When that happens we will send you a new Policy, Rider or Amendment pages.

No one can make any changes to this Policy unless those changes are in writing.

Other Information You Should Have

We have the right to change, interpret, modify, withdraw or add Benefits, or to terminate this Policy, as permitted by law.

This Policy will remain in effect as long as the Premium is paid when due, subject to the renewal and termination provisions of this Policy.

We are delivering this Policy in the State of Arizona. This Policy is governed by the laws of the State of Arizona.

Introduction to Your Policy

We are pleased to provide you with this Policy. This Policy describes your Benefits, as well as your rights and responsibilities, under this Policy.

How to Use this Document

We encourage you to read your Policy and any attached Riders and/or Amendments carefully.

We especially encourage you to review the Benefit limitations of this Policy by reading the attached *Schedule of Benefits* along with *Section 1: Covered Health Services* and *Section 2: Exclusions and Limitations*. You should also carefully read *Section 7: General Legal Provisions* to better understand how this Policy and your Benefits work. You should call us if you have questions about the limits of the coverage available to you.

Many of the sections of this Policy are related to other sections of the document. You may not have all of the information you need by reading just one section. We also encourage you to keep your Policy and *Schedule of Benefits* and any attachments in a safe place for your future reference.

If there is a conflict between this Policy and any summaries provided to you, this Policy will control.

Please be aware that your Physician is not responsible for knowing or communicating your Benefits.

Information about Defined Terms

Because this Policy is a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in *Section 8: Defined Terms*. You can refer to *Section 8: Defined Terms* as you read this document to have a clearer understanding of your Policy.

When we use the words "we," "us," and "our" in this document, we are referring to All Savers Insurance Company. When we use the words "you" and "your," we are referring to people who are Covered Persons, as that term is defined in *Section 8: Defined Terms*.

Don't Hesitate to Contact Us

Throughout the document you will find statements that encourage you to contact us for further information. Whenever you have a question or concern regarding your Benefits, please call us using the telephone number for *Customer Care* listed on your identification (ID) card. It will be our pleasure to assist you.

Your Responsibilities

Be Enrolled and Pay Required Premiums

Benefits are available to you only if you are enrolled for coverage under this Policy. Your enrollment options, and the corresponding dates that coverage begins, are listed in *Section 3: When Coverage Begins and Premiums*. To be enrolled with us and receive Benefits, all of the following apply:

- Your enrollment must be in accordance with this Policy, including the eligibility requirements.
- You must qualify as a Policyholder or his or her Dependent as those terms are defined in *Section 8: Defined Terms*.
- You must pay Premium as required.

Be Aware this Policy Does Not Pay for All Health Services

Your right to Benefits is limited to Covered Health Services, subject to the conditions, limitations and exclusions of this Policy. The extent of this Policy's payments for Covered Health Services and any obligation that you may have to pay for a portion of the cost of those Covered Health Services is set forth in the *Schedule of Benefits*.

Decide What Services You Should Receive

Care decisions are between you and your Physicians. We do not make decisions about the kind of care you should or should not receive.

Choose Your Physician

It is your responsibility to select the health care professionals who will deliver care to you. We arrange for Physicians and other health care professionals and facilities to participate in a Network. Our credentialing process confirms public information about the professionals' and facilities' licenses and other credentials, but does not assure the quality of their services. These professionals and facilities are independent practitioners and entities that are solely responsible for the care they deliver.

Obtain Prior Authorization

Some Covered Health Services require prior authorization. In general, Physicians and other health care professionals who participate in a Network are responsible for obtaining prior authorization. However, if you choose to receive Covered Health Services from a non-Network provider, you are responsible for obtaining prior authorization before you receive the services. For detailed information on the Covered Health Services that require prior authorization, please refer to the *Schedule of Benefits*.

Pay Your Share

You must meet any applicable deductible and pay a Copayment and/or Coinsurance for most Covered Health Services. These payments are due at the time of service or when billed by the Physician, provider or facility. Copayment and Coinsurance amounts are listed in the *Schedule of Benefits*. You must also pay any amount that exceeds Eligible Expenses.

Pay the Cost of Excluded Services

You must pay the cost of all excluded services and items. Review *Section 2: Exclusions and Limitations* to become familiar with this Policy's exclusions.

Show Your ID Card

You should show your identification (ID) card every time you request health services. If you do not show your ID card, the provider may fail to bill the correct entity for the services delivered, and any resulting delay may mean that you will be unable to collect any Benefits otherwise owed to you.

File Claims with Complete and Accurate Information

When you receive Covered Health Services from a non-Network, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described in *Section 5: How to File a Claim*.

Use Your Prior Health Care Coverage

If you have prior coverage that, as required by state law, extends benefits for a particular condition or a disability, we will not pay Benefits for health services for that condition or disability until the prior coverage ends. We will pay Benefits as of the day your coverage begins under this Policy for all other Covered Health Services that are not related to the condition or disability for which you have other coverage.

Our Responsibilities

Determine Benefits

We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

We will determine the following:

- Interpret Benefits and the other terms, limitations and exclusions set out in this Policy, the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations relating to Benefits.

We may delegate this authority to other persons or entities that may provide administrative services for this Policy, such as claims processing. The identity of the service providers and the nature of their services may be changed from time to time, as we determine. In order to receive Benefits, you must cooperate with those service providers.

Pay for Our Portion of the Cost of Covered Health Services

We pay Benefits for Covered Health Services as described in *Section 1: Covered Health Services* and in the *Schedule of Benefits*, unless the service is excluded in *Section 2: Exclusions and Limitations*. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by this Policy.

Pay Network Providers

It is the responsibility of Network Physicians and facilities to file for payment from us. When you receive Covered Health Services from Network providers, you do not have to submit a claim to us.

Pay for Covered Health Services Provided by Non-Network Providers

In accordance with any state prompt pay requirements, we will pay Benefits after we receive your request for payment that includes all required information. See *Section 5: How to File a Claim*.

Review and Determine Benefits in Accordance with our Reimbursement Policies

We develop our reimbursement policy guidelines in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that we accept.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), our reimbursement policies are applied to provider billings. We share our reimbursement policies with Physicians and other providers in our Network through our provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by our reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition, and may bill you for any amounts we do not pay, including amounts that are denied because one of our reimbursement policies does not reimburse (in whole or in part) for the services billed. You

may obtain copies of our reimbursement policies for yourself or to share with your non-Network Physician or provider by calling *Customer Care* at the telephone number on your ID card.

Offer Health Education Services to You

From time to time, we may provide you with access to information about additional services that are available to you, such as disease management programs, health education and patient advocacy. It is solely your decision whether to participate in the programs, but we recommend that you discuss them with your Physician.

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Section 1: Covered Health Services

Benefits for Covered Health Services

Benefits are available only if all of the following are true:

- The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary. (See definitions of Medically Necessary and Covered Health Service in *Section 8: Defined Terms*.) The fact that a Physician or other provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment for a Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms does not mean that the procedure or treatment is a Covered Health Service under this Policy.
- Covered Health Services are received while this Policy is in effect.
- Covered Health Services are received prior to the date that any of the individual termination conditions listed in *Section 4: When Coverage Ends* occurs.
- The person who receives Covered Health Services is a Covered Person and meets all eligibility requirements.

This section describes Covered Health Services for which Benefits are available. Please refer to the attached *Schedule of Benefits* for details about:

- The amount you must pay for these Covered Health Services (including any Annual Deductible, Per Occurrence Deductible, Copayment and/or Coinsurance).
- Any limit that applies to these Covered Health Services (including visit, day and dollar limits on services).
- Any limit that applies to the amount of Eligible Expenses you are required to pay in a year (Out-of-Pocket Maximum).
- Any responsibility you have for obtaining prior authorization or notifying us.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

1. Ambulance Services

Emergency Ambulance Services, without prior authorization, to the nearest Hospital or other facility that is licensed or otherwise authorized to furnish Emergency Health Services.

"Emergency Ambulance Services" means transportation services provided by an ambulance service by means of ground, air or water following the onset of a medical condition that manifests itself by symptoms of pain, illness, or Injury that could reasonably be expected to result in any of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Non-Emergency Ambulance Services between facilities when the transport is any of the following:

- From a non-Network Hospital to a Network Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care facility.

- From an acute facility to a sub-acute setting.

2. Clinical Trials

Routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of:

- Cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
- Cardiovascular disease (cardiac/stroke) which is not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Surgical musculoskeletal disorders of the spine, hip and knees, which are not life threatening, for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.
- Other diseases or disorders which are not life threatening for which, as we determine, a clinical trial meets the qualifying clinical trial criteria stated below.

Benefits include the reasonable and necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial.

Benefits are available only when the Covered Person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher.

Routine patient care costs for qualifying clinical trials include:

- Covered Health Services for which Benefits are typically provided absent a clinical trial.
- Covered Health Services required solely for the provision of the Experimental or Investigational Service(s) or item, the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications.
- Covered Health Services needed for reasonable and necessary care arising from the provision of an Experimental or Investigational Service(s) or item.

Routine costs for clinical trials do not include:

- The Experimental or Investigational Service(s) or item. The only exceptions to this are:
 - Certain *Category B* devices.
 - Certain promising interventions for patients with terminal illnesses.
 - Other items and services that meet specified criteria in accordance with our medical and drug policies.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below.

With respect to cardiovascular disease or musculoskeletal disorders of the spine, hip and knees and other diseases or disorders which are not life-threatening, a qualifying clinical trial is a Phase I, Phase II, or Phase III clinical trial that is conducted in relation to the detection or treatment of such non-life-threatening disease or disorder and which meets any of the following criteria in the bulleted list below.

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - *National Institutes of Health (NIH)*. (Includes *National Cancer Institute (NCI)*.)
 - *Centers for Disease Control and Prevention (CDC)*.
 - *Agency for Healthcare Research and Quality (AHRQ)*.
 - *Centers for Medicare and Medicaid Services (CMS)*.
 - A cooperative group or center of any of the entities described above or the *Department of Defense (DOD)* or the *Veterans Administration (VA)*.
 - A qualified non-governmental research entity identified in the guidelines issued by the *National Institutes of Health* for center support grants.
 - The *Department of Veterans Affairs*, the *Department of Defense* or the *Department of Energy* as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the *Secretary of Health and Human Services* to meet both of the following criteria:
 - ♦ Comparable to the system of peer review of studies and investigations used by the *National Institutes of Health*.
 - ♦ Ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- The study or investigation is conducted under an investigational new drug application reviewed by the *U.S. Food and Drug Administration*.
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.
- The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (*IRBs*) before participants are enrolled in the trial. We may, at any time, request documentation about the trial.
- The subject or purpose of the trial must be the evaluation of an item or service that meets the definition of a Covered Health Service and is not otherwise excluded under this Policy.
- With respect to a clinical trial for the treatment of cancer, the personnel providing the treatment or conducting the study:
 - Are providing the treatment or conducting the study within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training, and volume of patients treated to maintain expertise.
- Agree to accept reimbursement as payment in full from us at rates that we establish and for Network Benefits that are not more than the level of reimbursement applicable to other similar services provided by any of our Network providers.

3. Diabetes Services

Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care

Outpatient self-management training for the treatment of diabetes, education and medical nutrition therapy services. Diabetes outpatient self-management training, education and medical nutrition therapy services must be ordered by a Physician and provided by appropriately licensed or registered healthcare professionals. Benefits for diabetes self-management training include training provided to a Covered Person, after the initial diagnosis, in the care and management of diabetes, including proper use of diabetes equipment and supplies.

Benefits under this section also include medical eye examinations (dilated retinal examinations) and preventive foot care for Covered Persons with diabetes, and to the extent coverage is required under Medicare, podiatric appliances for prevention of complications associated with diabetes.

Benefits are available for therapeutic shoes for diabetes mellitus and any of the following complications involving the foot: Peripheral neuropathy with evidence of callus formation; or history or pre-ulcerative calluses; or history of previous ulceration; or foot deformity; or previous amputation of the foot or part of the foot; or poor circulation.

Diabetic Self-Management Items

Insulin pumps and supplies for the management and treatment of diabetes, based upon the medical needs of the Covered Person. An insulin pump is subject to all the conditions of coverage stated under *Durable Medical Equipment*. Benefits for blood glucose monitors, insulin syringes, test strips, and other diabetic supplies are described under the *Outpatient Prescription Drug Rider*.

4. Durable Medical Equipment

Durable Medical Equipment that meets each of the following criteria:

- Ordered or provided by a Physician for outpatient use.
- Appropriate for use in the home.
- Used for medical purposes.
- Not consumable or disposable except as needed for the effective use of covered Durable Medical Equipment.
- Not of use to a person in the absence of a disease or disability.

Benefits under this section include Durable Medical Equipment provided to you by a Physician.

If more than one piece of Durable Medical Equipment can meet your functional needs, Benefits are available only for the equipment that meets the minimum specifications for your needs.

Examples of Durable Medical Equipment include:

- Equipment to assist mobility, such as a standard wheelchair.
- A standard Hospital-type bed.
- Oxygen and the rental of equipment to administer oxygen (including tubing, connectors and masks).
- Delivery pumps for tube feedings (including tubing and connectors).
- Negative pressure wound therapy pumps (wound vacuums).
- Braces, including necessary adjustments to shoes to accommodate braces. Braces that stabilize an injured body part and braces to treat curvature of the spine are considered Durable Medical Equipment and are a Covered Health Service. Braces that straighten or change the shape of a body part are orthotic devices, and are excluded from coverage. Dental braces are also excluded from coverage. This exclusion for orthotic devices does not apply to foot orthotic devices and inserts for the treatment of diabetes as described under *Diabetes Services* in *Section 1: Covered Health Services*.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure (except that air-conditioners, humidifiers, dehumidifiers, air purifiers and filters and personal comfort items are excluded from coverage).
- Burn garments.
- Insulin pumps and all related necessary supplies as described under *Diabetes Services*.

- External cochlear devices and systems. Benefits for cochlear implantation are provided under the applicable medical/surgical Benefit categories in this Policy.

Benefits under this section do not include any device, appliance, pump, machine, stimulator, or monitor that is fully implanted into the body.

We will decide if the equipment should be purchased or rented.

Benefits are available for repairs and replacement, except that:

- Benefits for repair and replacement do not apply to damage due to misuse, malicious breakage or gross neglect.
- Benefits are not available to replace lost items.

5. Emergency Health Services - Outpatient

A screening examination and services that are required to stabilize or initiate treatment in an Emergency, including the assessment and stabilization of a psychiatric emergency medical condition. Emergency Health Services must be received on an outpatient basis at a Hospital or Alternate Facility. Emergency Health Services do not require prior authorization.

Benefits under this section include the facility charge, supplies and all professional services required to stabilize your condition and/or initiate treatment. This includes placement in an observation bed for the purpose of monitoring your condition (rather than being admitted to a Hospital for an Inpatient Stay).

Benefits under this section are not available for services to treat a condition that does not meet the definition of an Emergency.

6. Habilitative Services - Outpatient Therapy

Benefits are provided for habilitative services provided for Covered Persons with a disabling condition when both of the following conditions are met:

- The treatment is administered by a licensed speech-language pathologist, licensed audiologist, licensed occupational therapist, licensed physical therapist, Physician, licensed nutritionist, licensed social worker or licensed psychologist.
- The initial or continued treatment must be proven and not Experimental or Investigational.

Benefits for habilitative services do not apply to those services that are solely educational in nature or otherwise paid under state or federal law for purely educational services. Custodial Care, respite care, day care, therapeutic recreation, vocational training and residential treatment are not habilitative services. A service that does not help the Covered Person to meet functional goals in a treatment plan within a prescribed time frame is not a habilitative service.

We may require that a treatment plan be provided, request medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is needed. When the treating provider anticipates that continued treatment is or will be required to permit the Covered Person to achieve demonstrable progress, we may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated duration of treatment, the anticipated goals of treatment, and how frequently the treatment plan will be updated.

For purposes of this Benefit, "habilitative services" means health care services that help a person keep, learn or improve skills and functioning for daily living.

Benefits for Durable Medical Equipment and prosthetic devices, when used as a component of habilitative services, are described under *Durable Medical Equipment* and *Prosthetic Devices*.

7. Home Health Care

Services received from a Home Health Agency that are both of the following:

- Ordered by a Physician.

- Provided in your home by a registered nurse, or provided by either a home health aide or licensed practical nurse and supervised by a registered nurse.

Benefits are available only when the Home Health Agency services are provided on a part-time, Intermittent Care schedule and when skilled care is required.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.
- It is not Custodial Care.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

8. Hospice Care

Hospice care that is recommended by a Physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members while the Covered Person is receiving hospice care. Benefits are available when hospice care is received from a licensed hospice agency.

Please contact us for more information regarding our guidelines for hospice care. You can contact us at the telephone number on your ID card.

9. Hospital - Inpatient Stay

Services and supplies provided during an Inpatient Stay in a Hospital. Benefits are available for:

- Surgical services performed during the Inpatient Stay.
- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Room and board in a Private Room (a room with one bed) when determined to be Medically Necessary.
- Private hospital rooms and/or Private Duty Nursing are only available during inpatient stays and determined to be Medically Necessary. Private Duty Nursing is available only in an inpatient setting when skilled nursing is not available from the facility. Custodial nursing is not covered.
- Physician services for radiologists, anesthesiologists, pathologists and Emergency room Physicians. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Medically Necessary implantable devices/prostheses. Implantable devices/prostheses are permanent or temporary internal aids and supports for non-functional body parts. This includes testicular implants following Medically Necessary surgical removal of the testicles. Benefits are also available for repairs, maintenance, or replacement of covered implantable devices/prostheses when Medically Necessary.

10. Lab, X-Ray and Diagnostics - Outpatient

Services for Sickness and Injury-related diagnostic purposes, received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office include:

- Lab and radiology/X-ray.
- Mammography.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Lab, X-ray and diagnostic services for preventive care are described under *Preventive Care Services*.

CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services are described under *Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient*.

11. Lab, X-Ray and Major Diagnostics - CT, PET Scans, MRI, MRA and Nuclear Medicine - Outpatient

Services for CT scans, PET scans, MRI, MRA, Brain Electrical Activity Mapping (BEAM), Electroconvulsive therapy (ECT), nuclear medicine and major diagnostic services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

12. Mental Health Services

Mental Health Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.
- Psychiatric Services.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special Mental Health Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Mental Health Services Benefit. The Mental Health Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your Mental Illness which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

13. Neurodevelopmental Disorders - Autism Spectrum Disorder Services

Medically Necessary psychiatric services for Autism Spectrum Disorders provided by or under the direction of an experienced psychiatrist and/or an experienced licensed psychiatric provider.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Service for which Benefits are available under the applicable medical Covered Health Services categories in this Policy.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.

Enhanced Autism Spectrum Disorder services that are focused on educational/behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as *Applied Behavioral Analysis (ABA)*).

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

14. Pharmaceutical Products - Outpatient

Pharmaceutical Products that are administered on an outpatient basis in a Hospital, Alternate Facility, Physician's office, or in a Covered Person's home.

Benefits under this section are provided only for Pharmaceutical Products which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy.

If you require certain Pharmaceutical Products, including specialty Pharmaceutical Products, we will direct you to a Designated Dispensing Entity with whom we have an arrangement to provide those Pharmaceutical Products. Such Dispensing Entities may include an outpatient pharmacy, specialty pharmacy, Home Health Agency provider, Hospital-affiliated pharmacy or hemophilia treatment center contracted pharmacy.

If you/your provider are directed to a Designated Dispensing Entity and you/your provider choose not to obtain your Pharmaceutical Product from a Designated Dispensing Entity, Network Benefits are not available for that Pharmaceutical Product.

Certain Pharmaceutical Products are subject to step therapy requirements. This means that in order to receive Benefits for such Pharmaceutical Products, you are required to use a different Pharmaceutical Product and/or prescription drug product first. You may determine whether a particular Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens and/or participation in health management programs. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

15. Physician Fees for Surgical and Medical Services

Physician fees for surgical procedures and other medical care received on an outpatient or inpatient basis in a Hospital, Skilled Nursing Facility, Inpatient Rehabilitation Facility or Alternate Facility, or for Physician house calls.

16. Physician's Office Services - Sickness and Injury

Services provided in a Physician's office for the diagnosis and treatment of a Sickness or Injury. Benefits are provided under this section regardless of whether the Physician's office is free-standing, located in a clinic or located in a Hospital.

Covered Health Services include medical education services that are provided in a Physician's office by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include nutritional evaluation and counseling provided by a Physician when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to: morbid obesity, diabetes, cardiovascular disease, hypertension, kidney disease, eating disorders, gastrointestinal disorders, food allergies, and hyperlipidemia.

Covered Health Services include outpatient contraceptive services, which include consultations, examinations, procedures and medical services related to the use of United States *Food and Drug Administration* (FDA) approved prescription contraceptive methods to prevent unintended pregnancies.

Covered Health Services include genetic counseling. Benefits are available for Genetic Testing which is ordered by the Physician and authorized in advance by us.

Benefits under this section include allergy injections and antigen administration. Benefits for allergy testing are provided under *Lab, X-Ray and Diagnostics - Outpatient*.

Covered Health Services for preventive care provided in a Physician's office are described under *Preventive Care Services*.

Benefits under this section include lab, radiology/X-ray or other diagnostic services performed in the Physician's office, including:

- Hearing exam when received as part of an annual physical examination. When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.
- Routine vision screening when received as part of an annual physical examination. When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.
- Diagnostic services rendered for infertility evaluation.

When a test is performed or a sample is drawn in the Physician's office and then sent outside the Physician's office for analysis or testing, Benefits for lab, radiology/X-rays and other diagnostic services that are performed outside the Physician's office are described in *Lab, X-ray and Diagnostics - Outpatient*.

Benefits under this section do not include CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services.

17. Pregnancy - Maternity Services

Benefits for Pregnancy include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

Both before and during a Pregnancy, Benefits include the services of a genetic counselor when provided or referred by a Physician. These Benefits are available to all Covered Persons in the immediate family. Covered Health Services include related tests and treatment.

We also have special prenatal programs to help during Pregnancy. They are completely voluntary and there is no extra cost for participating in the program. To sign up, you should notify us during the first trimester, but no later than one month prior to the anticipated childbirth. It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs designed to achieve the best outcomes for you and your baby.

We will pay Benefits for an Inpatient Stay or Birthing Center of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery.
- 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending provider may discharge the mother and/or the newborn child earlier than these minimum time frames.

Benefits are available for maternity-related medical, Hospital and other Covered Health Services for the birth of any child legally adopted by the Policyholder if all of the following are true:

- The child is adopted within one year of birth.
- The Policyholder is legally obligated to pay the costs of birth.
- The Policyholder has notified us of his or her acceptability to adopt children within 60 days after approval is received or within 60 days after a change in health care coverage.

18. Preventive Care Services

Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*, including counseling and interventions to prevent tobacco use and tobacco-related diseases in adults and pregnant women counseling and interventions.
- Immunizations that have in effect a recommendation from the *Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention*.
- Family planning services. Benefits under this section include:
 - Medical history;
 - Physical examination;
 - Related laboratory tests;
 - Medical supervision in accordance with generally accepted medical practice;
 - Information and counseling on contraception;
 - Implanted/injected contraceptives; and
 - After appropriate counseling medical services connected with surgical therapies (vasectomy or tubal ligation).
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*. Benefits under this section include:
 - Well child visits and immunizations are covered through 47 months as recommended by the *American Academy of Pediatrics*.
 - Screening newborns for hearing problems, thyroid disease, phenylketonuria, sickle cell anemia, and standard metabolic screening panel for inherited enzyme deficiency diseases.
 - For children: Counseling for fluoride for prevention of dental cavities; screening for major depressive disorders; vision; lead; tuberculosis; developmental disorders/Autism Spectrum Disorders; counseling for obesity.
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*. Benefits under this section include:
 - Preventive care visits to include preconception and prenatal services.
 - Voluntary family planning and contraceptive services, which include, but are not limited to the following services:
 - ♦ Office visits and examinations (includes family planning counseling or consultations to obtain internally implanted time-release contraceptives or intrauterine devices).
 - ♦ Contraceptive medication, insertions and injections (e.g. Norplant, Depo-Provera).
 - ♦ Contraceptive device fittings, insertions and removals (e.g., IUDs, diaphragms, cervical caps).
 - ♦ Female sterilization methods, including surgical sterilization (tubal ligation) and implantable sterilization (e.g. Essure).
 - Breastfeeding support and counseling, includes lactation support counseling during pregnancy and/or in the post-partum period.
 - Human papillomavirus (HPV) DNA testing for women 30 years and older.
 - Domestic violence screening and counseling.
 - Annual human immunodeficiency virus (HIV) screening and counseling.

- Annual sexually-transmitted infection counseling.
- Screening for gestational diabetes for all pregnant women that have not prior history of diabetes.
- Genetic counseling and evaluation for routine breast cancer susceptibility gene (BRCA) testing.
- Osteoporosis screening.

Benefits defined under the *Health Resources and Services Administration (HRSA)* requirement include the cost of renting one breast pump per Pregnancy in conjunction with childbirth. Breast pumps must be ordered by or provided by a Physician. You can obtain additional information on how to access Benefits for breast pumps by calling *Customer Care* at the telephone number on your ID card.

If more than one breast pump can meet your needs, Benefits are available only for the most cost effective pump. We will determine the following:

- Which pump is the most cost effective.
- Whether the pump should be purchased or rented.
- Duration of a rental.
- Timing of an acquisition.

Benefits for screening mammography are provided, at a minimum, according to the following guidelines:

- A single baseline mammogram for a woman age 35 through 39.
- A mammogram every year for a woman age 40 and older.
- Non-routine mammograms will be covered more frequently based on the recommendation of the woman's Physician.
- With respect to men, screening for prostate cancer for all men age 40 and older or under age 40 years of age if at high risk due to family history, race or previous borderline prostate specific antigen levels and screening for abdominal aortic aneurysm in men 65-75 years old.
- With respect to all Covered Persons at an appropriate age and/or risk status, Benefits under this section include:
 - Counseling and/or screening for: colorectal cancer, elevated cholesterol and lipids; sexually transmitted diseases; human immunodeficiency virus (HIV); depression; high blood pressure; diabetes.
 - Screening and counseling for alcohol abuse in a primary care setting; obesity; diet and nutrition.
 - Behavioral counseling to prevent skin cancer for Covered Persons ages 10 to 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Benefits for Preventive Care Medications are provided as described under the *Outpatient Prescription Drug Rider*.

You may view the list of "A" and "B" preventive services recommended by the *United States Preventive Task Force* at www.uspreventiveservicestaskforce.org/uspstf/uspabrecs.htm and the women's preventive services at www.hrsa.gov/womensguidelines/. If you do not have internet access, please contact us at the telephone number on your ID card.

19. Prosthetic Devices

External prosthetic devices that replace a limb or a body part, limited to:

- Artificial arms, legs, feet and hands.
- Artificial face, eyes, ears and nose.
- Breast prosthesis as required by the *Women's Health and Cancer Rights Act of 1998*. Benefits include mastectomy bras and lymphedema stockings for the arm.

Benefits under this section are provided only for external prosthetic devices. Medically Necessary implantable devices/prostheses are covered as described under *Outpatient Surgery* in *Section 1: Covered Health Services*.

If more than one prosthetic device can meet your functional needs, Benefits are available only for the prosthetic device that meets the minimum specifications for your needs. If you purchase a prosthetic device that exceeds these minimum specifications, we will pay only the amount that we would have paid for the prosthetic that meets the minimum specifications, and you will be responsible for paying any difference in cost.

The prosthetic device must be ordered or provided by, or under the direction of a Physician.

Benefits are available for repairs and replacement, including replacement when necessitated by normal anatomical growth or as a result of wear and tear. Benefits are not available for repairs and replacement when:

- There are no Benefits for repairs due to misuse, malicious damage or gross neglect.
- There are no Benefits for replacement due to misuse, malicious damage, gross neglect or for lost or stolen prosthetic devices.

20. Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures which are associated with an Injury, Sickness or Congenital Anomaly.

Cosmetic Procedures are covered for reconstructive surgery that constitutes necessary care and treatment of medically diagnosed services required for the prompt repair of accidental injury. Congenital defects and birth abnormalities are covered for eligible Dependent children.

Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures and are excluded from coverage. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

Please note that Benefits for reconstructive procedures include breast reconstruction following a mastectomy, and reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including breast prostheses (at least two external post-operative breast prostheses) and treatment of complications (including lymphedemas), are provided in the same manner and at the same level as those for any other Covered Health Service. You can contact us at the telephone number on your ID card for more information about Benefits for mastectomy-related services.

21. Rehabilitation Services - Outpatient Therapy

Short-term outpatient rehabilitation services (including habilitative services), limited to:

- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Pulmonary rehabilitation therapy.

- Cardiac rehabilitation therapy.
- Post-cochlear implant aural therapy.
- Cognitive rehabilitation therapy.

Rehabilitation services must be performed by a Physician or by a licensed therapy provider. Benefits under this section include rehabilitation services provided in a Physician's office or on an outpatient basis at a Hospital or Alternate Facility.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if rehabilitation goals have previously been met.

Please note that we will pay Benefits for speech therapy for the treatment of disorders of speech, language, voice, communication and auditory processing only when the disorder results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder. We will pay Benefits for cognitive rehabilitation therapy only when Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.

22. Scopic Procedures - Outpatient Diagnostic and Therapeutic

Diagnostic and therapeutic scopic procedures and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Diagnostic scopic procedures are those for visualization, biopsy and polyp removal. Examples of diagnostic scopic procedures include colonoscopy, sigmoidoscopy and endoscopy.

Please note that Benefits under this section do not include surgical scopic procedures, which are for the purpose of performing surgery. Benefits for surgical scopic procedures are described under *Surgery - Outpatient*. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for all other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

When these services are performed for preventive screening purposes, Benefits are described under *Preventive Care Services*.

23. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

Services and supplies provided during an Inpatient Stay in a Skilled Nursing Facility or Inpatient Rehabilitation Facility. Benefits are available for:

- Supplies and non-Physician services received during the Inpatient Stay.
- Room and board in a Semi-private Room (a room with two or more beds).
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)

Please note that Benefits are available only if both of the following are true:

- If the initial confinement in a Skilled Nursing Facility or Inpatient Rehabilitation Facility was or will be a cost effective alternative to an Inpatient Stay in a Hospital.
- You will receive skilled care services that are not primarily Custodial Care.

Skilled care is skilled nursing, skilled teaching and skilled rehabilitation services when all of the following are true:

- It must be delivered or supervised by licensed technical or professional medical personnel in order to obtain the specified medical outcome, and provide for the safety of the patient.
- It is ordered by a Physician.
- It is not delivered for the purpose of assisting with activities of daily living, including dressing, feeding, bathing or transferring from a bed to a chair.
- It requires clinical training in order to be delivered safely and effectively.

We will determine if Benefits are available by reviewing both the skilled nature of the service and the need for Physician-directed medical management. A service will not be determined to be "skilled" simply because there is not an available caregiver.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed rehabilitation services or if discharge rehabilitation goals have previously been met.

24. Substance-Related and Addictive Disorders Services

Substance-Related and Addictive Disorders Services include those received on an inpatient basis in a Hospital or an Alternate Facility, and those received on an outpatient basis in a provider's office or at an Alternate Facility.

Benefits include the following services provided on either an inpatient or outpatient basis:

- Diagnostic evaluations and assessment.
- Treatment planning.
- Treatment and/or procedures.
- Referral services.
- Medication management.
- Individual, family, therapeutic group and provider-based case management services.
- Crisis intervention.
- Partial Hospitalization/Day Treatment.
- Services at a Residential Treatment Facility.
- Intensive Outpatient Treatment.
- Detoxification and medical detoxification including related medical ancillary services.

The Mental Health/Substance-Related and Addictive Disorders Designee determines coverage for all levels of care. If an Inpatient Stay is required, it is covered on a Semi-private Room basis.

We encourage you to contact the Mental Health/Substance-Related and Addictive Disorders Designee for referrals to providers and coordination of care.

Special-Related and Addictive Disorders Programs and Services

Special programs and services that are contracted under the Mental Health/Substance-Related and Addictive Disorders Designee may become available to you as a part of your Substance-Related and Addictive Disorders Services Benefit. The Substance-Related and Addictive Disorders Services Benefits and financial requirements assigned to these programs or services are based on the designation of the program or service to inpatient, Partial Hospitalization/Day Treatment, Intensive Outpatient Treatment, outpatient or a Transitional Care category of Benefit use. Special programs or services provide access to services that are beneficial for the treatment of your substance-related and addictive disorders which may not otherwise be covered under this Policy. You must be referred to such programs through the Mental Health/Substance-Related and Addictive Disorders Designee, who is responsible for coordinating your care or through other pathways as described in the program introductions. Any decision to participate in such a program or service is at the discretion of the Covered Person and is not mandatory.

25. Surgery - Outpatient

Surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include certain scopic procedures. Examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy.

Benefits under this section also include vasectomy procedures. (Benefits for female sterilization methods are described under *Preventive Care Services*).

Examples of surgical procedures performed in a Physician's office are mole removal and ear wax removal.

Benefits under this section include:

- The facility charge and the charge for supplies and equipment.
- Physician services for radiologists, anesthesiologists and pathologists. (Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.)
- Medically Necessary implantable devices/prostheses. Implantable devices/prostheses are permanent or temporary internal aids and supports for non-functional body parts. This includes testicular implants following Medically Necessary surgical removal of the testicles. Benefits are also available for repairs, maintenance, or replacement of covered implantable devices/prostheses when Medically Necessary.

Benefits for external prosthetic devices are covered as described under *Prosthetic Devices* in *Section 1: Covered Health Services*.

26. Therapeutic Treatments - Outpatient

Therapeutic treatments received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy and radiation oncology.

Covered Health Services include medical education services that are provided on an outpatient basis at a Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when both of the following are true:

- Education is required for a disease in which patient self-management is an important component of treatment.
- There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include nutritional evaluation and counseling provided by a Physician when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to: morbid obesity, diabetes, cardiovascular disease, hypertension, kidney disease, eating disorders, gastrointestinal disorders, food allergies, and hyperlipidemia.

Benefits under this section include:

- The facility charge and the charge for related supplies and equipment.
- Physician services for anesthesiologists, pathologists and radiologists. Benefits for other Physician services are described under *Physician Fees for Surgical and Medical Services*.

27. Transplantation Services

Organ and tissue transplants when ordered by a Physician. Benefits are available for transplants when the transplant meets the definition of a Covered Health Service, and is not an Experimental or Investigational or Unproven Service. Covered Health Services also include the cost for organ procurement.

Examples of transplants for which Benefits are available include allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, heart, heart/lung, lung, kidney, kidney/pancreas, kidney/liver, liver, liver/small bowel, pancreas, small bowel and cornea.

Donor costs that are directly related to organ removal are Covered Health Services for which Benefits are payable through the organ recipient's coverage under this Policy.

We have specific guidelines regarding Benefits for transplant services. Contact us at the telephone number on your ID card for information about these guidelines.

Benefits for Transplantation Travel Services:

Travel expenses incurred by the Covered Person in connection with a prior authorized organ and/or tissue transplant are covered subject to the following conditions and limitations:

- Travel expenses are limited to \$10,000.
- Benefits for organ transplant travel expenses are not available for cornea transplants.
- Benefits for transportation, lodging and food are available only for the Covered Person receiving a prior-authorized organ and/or tissue transplant or transplant related services from a Network transplant facility designated by us. Transplant related services include evaluation, candidacy, transplant event, or post-transplant care.

All claims filed for travel expenses must include detailed receipts, except for mileage. Transportation mileage will be calculated based on the home address of the Covered Person and the transplant facility location. Travel expenses for the Covered Person receiving the transplant will include charges for:

- Transportation to and from the transplant facility location (including charges for a rental car used during a period of care at the transplant facility).
- Transportation to and from the transplant site in a personal vehicle will be reimbursed per mile (at the rate set by the Internal Revenue Service for medical purposes in effect at the time of travel) when the transplant facility location is more than 60 miles one way from the Covered Person's home.
- Lodging while at, or traveling to and from the transplant facility location.
- Food while at, or traveling to and from the transplant facility location.

In addition to the covered travel expenses listed above, Benefits for travel expenses are also available for one companion to accompany the Covered Person receiving the transplantation services. The term companion includes the Covered Person's spouse, a member of the Covered Person's family, the Covered Person's legal guardian, or any person not related to the Covered Person, but actively involved as his or her caregiver. Expenses incurred by the Covered Person's companion will be accumulated toward the Covered Person's \$10,000 limit per transplantation service described above.

28. Urgent Care Center Services

Covered Health Services received at an Urgent Care Center. When services to treat urgent health care needs are provided in a Physician's office, Benefits are available as described under *Physician's Office Services - Sickness and Injury*.

29. Virtual Visits

Virtual visits for Covered Health Services that include the diagnosis and treatment of low acuity medical conditions for Covered Persons through the use of interactive audio and video telecommunication and transmissions, and audio-visual communication technology. Virtual visits provide communication of medical information in real-time between the patient and a distant Physician or health specialist, through use of interactive audio and video communications equipment outside of a medical facility (for example, from home or from work).

Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

Please Note: Not all medical conditions can be appropriately treated through virtual visits. The Designated Virtual Network Provider will identify any condition for which treatment by in-person Physician contact is necessary.

Benefits under this section do not include email , fax and standard telephone calls, or for telehealth/telemedicine visits that occur within medical facilities (CMS defined originating facilities).

Additional Benefits Required By Arizona Law

30. Dental Services - Accident Only

Dental services when all of the following are true:

- Treatment is necessary because of accidental damage.
- Dental services are received from a Doctor of Dental Surgery or Doctor of Medical Dentistry.

Please note that dental damage that occurs as a result of normal activities of daily living or extraordinary use of the teeth is not considered having occurred as an accident. Benefits are not available for repairs to teeth that are damaged as a result of such activities.

Dental services to repair damage caused by accidental Injury must conform to the following time-frames:

- Treatment is started within six months of the accident, unless extenuating circumstances exist (such as prolonged hospitalization or the presence of fixation wires from fracture care).

Benefits for treatment of accidental Injury are limited to the following:

- Emergency examination.
- Necessary diagnostic X-rays.
- Endodontic (root canal) treatment.
- Temporary splinting of teeth.
- Prefabricated post and core.
- Simple minimal restorative procedures (fillings).
- Extractions.
- Post-traumatic crowns if such are the only clinically acceptable treatment.
- Replacement of lost teeth due to the Injury by implant, dentures or bridges.

31. Dental Services - Hospital or Alternative Facility/Anesthesia

Benefits for general anesthesia and associated Hospital or Alternative Facility charges in connection with dental services for oral surgery are available when the Covered Person's underlying medical condition requires general anesthesia to be rendered in a Hospital or Alternative Facility setting. Underlying medical conditions include heart problems, diabetes, hemophilia, dental extractions due to cancer related conditions, and the probability of allergic reaction (or any other condition that could increase the danger of anesthesia).

32. Hearing Aids

Hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Benefits are available for a hearing aid that is purchased as a result of a written recommendation by a Physician. Benefits are provided for the hearing aid and for charges for associated fitting and testing.

Benefits under this section do not include bone anchored hearing aids. Bone anchored hearing aids are a Covered Health Service for which Benefits are available under the applicable medical/surgical Covered Health Services categories in this Certificate, only for Covered Persons who have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

33. Manipulative Treatment

Benefits are available for Manipulative Treatment when performed by a Physician or licensed chiropractic provider.

Benefits can be denied or shortened for Covered Persons who are not progressing in goal-directed Manipulative Treatment or if treatment goals have previously been met. Benefits under this section are not available for maintenance/preventive Manipulative Treatment.

34. Obesity Surgery

Benefits for obesity surgery are provided when all criteria below are met. Benefits are limited to the following procedures:

- Open roux-en-y gastric bypass (RYGBP).
- Laparoscopic roux-en-y gastric bypass (RYGBP)
- Laparoscopic or open adjustable gastric banding (LAGB).
- Laparoscopic or open biliopancreatic diversion and a duodenal switch (BPD/DS).
- Laparoscopic or open sleeve gastrectomy (SG).
- Laparoscopic or open gastric bypass procedures.

All of the following criteria must be met in order for a Covered Person to qualify for Benefits for obesity surgery:

- Be 18 years or older, or have reached full expected skeletal growth. If the surgical candidate is less than 18 years of age, qualification can be granted if body development consistent with Tanner state 4 is present and 95% of adult height has been reached.
- Have a body-mass index (BMI) equal to or greater than 35 and have at least one significant co-morbidity related to obesity. If the body-mass index (BMI) is equal to or greater than 40, no co-morbidity is required in order to qualify for surgery. (Co-morbidity is either the presence of one or more disorders (or diseases) in addition to a primary disease or disorder, or the effect of such additional disorders or diseases.) Examples of co-morbidity include type 2 diabetes, hypertension which is not adequately controlled with pharmacotherapy and moderate to severe obstructive sleep apnea, as defined on the Apnea/Hypopnea Index (AHI).
- Have been previously unsuccessful with medical treatment for obesity as described below. The following medical information must be documented in the Covered Person's medical record:

Have actively participated (within the last two years) in one Physician-supervised weight-management program for a minimum of six months without significant gaps (defined as no dietary visits for greater than 2 months). The weight-management program must include monthly documentation of all of the following components:

- Weight.

- Current dietary program.
- Physical activity, such as an exercise program.

If treatment was directly paid or covered by another plan, Benefits will be provided for Medically Necessary adjustments including Benefits for all complications (excluding the ability to lose weight, which is not a complication of surgery).

As noted above, Benefits are provided for the treatment of actual surgical complications. (Complications are defined as unexpected or unanticipated condition superimposed on an existing disease affecting or modifying the prognosis of the original disease or condition, for example, bleeding or infections that requires hospitalization.) Failure of a medical or surgical treatment to achieve its desired objective, of itself, is not a complication. Failure to lose weight, of itself, is not a complication.

35. Orthognathic Surgery

Orthognathic treatment/surgery, dental and orthodontic services and/or appliances that are orthodontic in nature or change the occlusion of the teeth (external or intra-oral) are provided when determined to be Medically Necessary.

36. Ostomy Supplies

Benefits for ostomy supplies which are medically appropriate for care and cleaning of a temporary or permanent ostomy. Covered supplies include:

- Pouches, face plates and belts.
- Irrigation sleeves, bags and ostomy irrigation catheters.
- Skin barriers.
- Gauze, adhesive, adhesive remover, deodorant, and pouch covers and other supplies when determined medically appropriate.

37. Telemedicine Services

Covered Health Services delivered through the use of interactive audio, video, or other electronic media by a provider for the purpose of diagnosis, consultation or treatment provided to a Covered Person receiving the service in a rural region of Arizona.

Telemedicine does not include the sole use of an audio-only telephone, a video-only system, a facsimile machine, instant messages or electronic mail.

Rural region means either:

- An area that is located in a county with a population of less than nine hundred thousand persons.
- A city or town that is located in a county with a population of nine hundred thousand persons or more and whose nearest boundary is more than thirty miles from the boundary of a city that has a population of five hundred thousand persons or more.

For the purposes of Telemedicine Services, Covered Health Services means services provided for the following conditions or in the following settings:

- Trauma.
- Burn.
- Cardiology.
- Infectious diseases.
- Mental health disorders.
- Neurologic diseases including strokes.

- Dermatology.

38. Temporomandibular Joint (TMJ) Services

Services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Non-surgical treatment including clinical examinations, physical therapy, pharmacological therapy, oral appliances (orthotic splints), joint injections and trigger-point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy and open or closed reduction of dislocations.

Covered Health Services under this section also include diagnosis and treatment of TMJ that is recognized by the medical or dental profession as effective and appropriate for TMJ, including intra-oral splints that stabilize the jaw joint.

39. Vision Correction after Surgery

Covered Health Services include Medically Necessary services provided for the initial prescription for contacts for treatment of keratoconus or post-cataract surgery.

Section 2: Exclusions and Limitations

How We Use Headings in this Section

To help you find specific exclusions more easily, we use headings (for example *A. Alternative Treatments* below). The headings group services, treatments, items, or supplies that fall into a similar category. Actual exclusions appear underneath headings. A heading does not create, define, modify, limit or expand an exclusion. All exclusions in this section apply to you.

We do not Pay Benefits for Exclusions

We will not pay Benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a Physician.
- It is the only available treatment for your condition.

The services, treatments, items or supplies listed in this section are not Covered Health Services, except as may be specifically provided for in *Section 1: Covered Health Services* or through a Rider to this Policy.

Benefit Limitations

When Benefits are limited within any of the Covered Health Service categories described in *Section 1: Covered Health Services*, those limits are stated in the corresponding Covered Health Service category in the *Schedule of Benefits*. Limits may also apply to some Covered Health Services that fall under more than one Covered Health Service category. When this occurs, those limits are also stated in the *Schedule of Benefits* under the heading *Benefit Limits*. Please review all limits carefully, as we will not pay Benefits for any of the services, treatments, items or supplies that exceed these Benefit limits.

Please note that in listing services or examples, when we say "this includes," it is not our intent to limit the description to that specific list. When we do intend to limit a list of services or examples, we state specifically that the list "is limited to."

A. Alternative Treatments

1. Acupressure and acupuncture.
2. Aromatherapy.
3. Hypnotism.
4. Massage therapy.
5. Rolfing.
6. Art therapy, music therapy, dance therapy, horseback therapy and other forms of alternative treatment as defined by the *National Center for Complementary and Alternative Medicine (NCCAM)* of the *National Institutes of Health*. This exclusion does not apply to non-manipulative osteopathic care for which Benefits are provided as described in *Section 1: Covered Health Services*.

B. Dental

1. Dental care (which includes dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia).

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.

This exclusion does not apply to Covered Persons with an underlying medical condition that requires general anesthesia to be rendered in a Hospital or Alternative Facility setting as described under *Dental Services - Hospital or Alternative Facility/Anesthesia* in *Section 1: Covered Health Services*.

This exclusion does not apply to Covered Dental Services for Covered Persons under the age of 19 for which benefits are provided as described in the *Pediatric Dental Services Rider*.

This exclusion does not apply to dental care (oral examination, X-rays, extractions and non-surgical elimination of oral infection) required for the direct treatment of a medical condition for which Benefits are available under this Policy, limited to:

- Transplant preparation.
- Prior to the initiation of immunosuppressive drugs.
- The direct treatment of acute traumatic Injury, cancer or cleft palate.

Dental care that is required to treat the effects of a medical condition, but that is not necessary to directly treat the medical condition, is excluded. Examples include treatment of dental caries resulting from dry mouth after radiation treatment or as a result of medication.

Endodontics, periodontal surgery and restorative treatment are excluded.

2. Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include:

- Extraction, restoration and replacement of teeth.
- Medical or surgical treatments of dental conditions.
- Services to improve dental clinical outcomes.

This exclusion does not apply to accident-related dental services for which Benefits are provided as described under *Dental Services - Accident Only* in *Section 1: Covered Health Services*.

This exclusion does not apply to Covered Dental Services for Covered Persons under the age of 19 for which Benefits are provided as described in the *Pediatric Dental Services Rider*.

3. Dental implants, bone grafts and other implant-related procedures.
4. Dental braces (orthodontics). This exclusion does not apply to orthodontic services for which Benefits are provided as described under *Orthognathic Surgery* in *Section 1: Covered Health Services*. This exclusion does not apply to Covered Dental Services for Covered Persons under the age of 19 for which Benefits are provided as described in the *Pediatric Dental Services Rider*.
5. Treatment of congenitally missing, malpositioned or supernumerary teeth, even if part of a Congenital Anomaly.

C. Devices, Appliances and Prosthetics

1. Devices used specifically as safety items or to affect performance in sports-related activities.
2. Orthotic appliances that straighten or re-shape a body part. Examples include foot orthotics and some types of braces, including over-the-counter orthotic braces. This exclusion does not apply to orthotic devices for the treatment of diabetes as described under *Diabetes Services* in *Section 1: Covered Health Services*.
3. Cranial banding.
4. The following items are excluded, even if prescribed by a Physician:
 - Blood pressure cuff/monitor.
 - Enuresis alarm.
 - Non-wearable external defibrillator.

- Trusses.
 - Ultrasonic nebulizers.
5. Devices and computers to assist in communication and speech.
 6. Oral appliances for snoring.
 7. Repairs to prosthetic devices due to misuse, malicious damage or gross neglect.
 8. Replacement of prosthetic devices due to misuse, malicious damage or gross neglect or to replace lost or stolen items.

D. Drugs

1. Self-injectable medications *except as described in the Outpatient Prescription Drug Rider*. This exclusion does not apply to medications which, due to their characteristics (as determined by us), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
2. Non-injectable medications given in a Physician's office. This exclusion does not apply to non-injectable medications that are required in an Emergency and consumed in the Physician's office.
3. Over-the-counter drugs and treatments. This exclusion does not apply to over-the-counter aids and/or drugs used for smoking cessation, aspirin or insulin for which Benefits are available as described in the *Outpatient Prescription Drug Rider* and other over-the-counter drugs recommended by the *United States Preventive Services Task Force* www.uspreventiveservicestaskforce.org/Page/Name/recommendations.
4. New Pharmaceutical Products and/or new dosage forms until the date they are reviewed.
5. A Pharmaceutical Product that contains (an) active ingredient(s) available in and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
6. A Pharmaceutical Product that contains (an) active ingredient(s) which is (are) a modified version of and therapeutically equivalent (having essentially the same efficacy and adverse effect profile) to another covered Pharmaceutical Product. Such determinations may be made up to six times during a calendar year.
7. Benefits for Pharmaceutical Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

E. Experimental or Investigational or Unproven Services

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.

This exclusion will also not apply to drugs prescribed for the treatment of cancer if the drug has been recognized by the *Food and Drug Administration* as safe and effective for treatment of that specific type of cancer in one or more of the following acceptable standard medical reference compendia, or in medical literature listed below:

- The acceptable standard medical reference compendia are the following:
 - ♦ *The American Hospital Formulary Service Drug Information*, a publication of the *American Society of Health System Pharmacists*.

- ♦ The *National Comprehensive Cancer Network Drugs and Biologics Compendium*.
- ♦ *Thomson Micromedex Compendium DRUGDEX*.
- ♦ *Elsevier Gold Standard's Clinical Pharmacology Compendium*.
- ♦ Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services*.
- Medical literature may be accepted if all of the following apply:
 - ♦ At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
 - ♦ No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
 - ♦ The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors*, or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant to Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B)).

F. Foot Care

1. Routine foot care. Examples include the cutting or removal of corns and calluses. This exclusion does not apply to preventive foot care for Covered Persons with diabetes for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
2. Nail trimming, cutting, or debriding.
3. Hygienic and preventive maintenance foot care. Examples include:
 - Cleaning and soaking the feet.
 - Applying skin creams in order to maintain skin tone.

This exclusion does not apply to preventive foot care for Covered Persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.
4. Treatment of flat feet.
5. Treatment of subluxation of the foot.
6. Shoes.
7. Shoe inserts.
8. Arch supports.

G. Medical Supplies

1. Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
 - Compression stockings.
 - Ace bandages.
 - Gauze and dressings.
 - Urinary catheters.

This exclusion does not apply to:

- Disposable supplies necessary for the effective use of Durable Medical Equipment for which Benefits are provided as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.
 - Diabetic supplies for which Benefits are provided as described under *Diabetes Services* in *Section 1: Covered Health Services*.
 - Ostomy supplies for which Benefits are provided as described under *Ostomy Supplies* in *Section 1: Covered Health Services*.
 - Medical supplies, which may be considered disposable, when obtained from a Network provider for treatment of a specific medical condition and determined to be Medically Necessary.
2. Tubings and masks except when used with Durable Medical Equipment as described under *Durable Medical Equipment* in *Section 1: Covered Health Services*.

H. Mental Health

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Mental Health Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Mental Health Services as treatments for R and T code conditions as listed within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Mental Health Services as treatment for a primary diagnosis of insomnia and other sleep-wake disorders, feeding disorders, binge eating disorders, sexual dysfunction, communication disorders, motor disorders, neurological disorders and other disorders with a known physical basis.
4. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
5. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
6. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
7. Motor disorders and primary communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
8. Intellectual disabilities as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.
9. Autism spectrum disorder as a primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*. Benefits for autism spectrum disorder as a primary diagnosis are described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.
10. Mental Health Services as a treatment for other conditions that may be a focus of clinical attention as listed in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
11. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
12. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services,

including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

I. Neurodevelopmental Disorders - Autism Spectrum Disorder

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Neurodevelopmental Disorders - Autism Spectrum Disorder Services* in *Section 1: Covered Health Services*.

1. Any treatments or other specialized services designed for Autism Spectrum Disorder that are not backed by credible research demonstrating that the services or supplies have a measurable and beneficial health outcome and therefore considered Experimental or Investigational or Unproven Services.
2. Intellectual disability as the primary diagnosis defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
3. Tuition for or services that are school-based for children and adolescents under the *Individuals with Disabilities Education Act*.
4. Learning, motor disorders and communication disorders as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association* and which are not a part of Autism Spectrum Disorder.
5. Treatments for the primary diagnoses of learning disabilities, conduct and impulse control disorders, personality disorders and paraphilic disorder.
6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Medically Necessary.
 - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

J. Nutrition

1. Individual and group nutritional counseling. This exclusion does not apply to medical nutritional education services that are provided by appropriately licensed or registered health care professionals when both of the following are true:
 - Nutritional education is required for a disease in which patient self-management is an important component of treatment.
 - There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits for nutritional evaluation are provided as described under *Physician's Office Services - Sickness and Injury* and *Therapeutic Treatments - Outpatient* in *Section 1: Covered Health Services*.

2. Enteral feedings, even if the sole source of nutrition. This exclusion does not apply to enteral feedings required for the treatment of Inherited Metabolic Disorder for which Benefits are provided as described in the *Outpatient Prescription Drug Rider*. See the Benefits for medical foods described under the *Outpatient Prescription Drug Rider*.
3. Infant formula and donor breast milk.
4. Nutritional or cosmetic therapy using high dose or mega quantities of vitamins, minerals or elements and other nutrition-based therapy. Examples include supplements, electrolytes and foods of any kind (including high protein foods and low carbohydrate foods). See the Benefits for eosinophilic gastrointestinal disorder formula described under the *Outpatient Prescription Drug Rider*.

K. Personal Care, Comfort or Convenience

1. Television.
2. Telephone.
3. Beauty/barber service.
4. Guest service.
5. Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
 - Air conditioners, air purifiers and filters and dehumidifiers.
 - Batteries, except for cochlear implants, and battery chargers.
 - Breast pumps. This exclusion does not apply to breast pumps for which Benefits are provided under the *Health Resources and Services Administration (HRSA)* requirement.
 - Car seats.
 - Chairs, bath chairs, feeding chairs, toddler chairs, chair lifts and recliners.
 - Exercise equipment.
 - Home modifications such as elevators, handrails and ramps.
 - Hot tubs.
 - Humidifiers.
 - Jacuzzis.
 - Mattresses.
 - Medical alert systems.
 - Motorized beds.
 - Music devices.
 - Personal computers.
 - Pillows.
 - Power-operated vehicles.
 - Radios.
 - Saunas.
 - Stair lifts and stair glides.
 - Strollers.
 - Safety equipment.

- Treadmills.
- Vehicle modifications such as van lifts.
- Video players.
- Whirlpools.

L. Physical Appearance

1. Cosmetic Procedures. See the definition in *Section 8: Defined Terms*. Examples include:
 - Pharmacological regimens, nutritional procedures or treatments.
 - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
 - Skin abrasion procedures performed as a treatment for acne.
 - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
 - Treatment for skin wrinkles or any treatment to improve the appearance of the skin.
 - Treatment for spider veins.
 - Hair removal or replacement by any means.
2. Replacement of an existing breast implant if the earlier breast implant was performed as a Cosmetic Procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy. See *Reconstructive Procedures* in *Section 1: Covered Health Services*.
3. Treatment of benign gynecomastia (abnormal breast enlargement in males).
4. Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility and diversion or general motivation.
5. Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.
6. Wigs regardless of the reason for the hair loss.

M. Procedures and Treatments

1. Excision or elimination of hanging skin on any part of the body. Examples include plastic surgery procedures called abdominoplasty or abdominal panniculectomy and brachioplasty.
2. Medical and surgical treatment of excessive sweating (hyperhidrosis).
3. Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea.
4. Rehabilitation services to improve general physical condition that are provided to reduce potential risk factors, where significant therapeutic improvement is not expected, including routine, long-term or maintenance/preventive treatment.
5. Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from Injury, stroke, cancer, Congenital Anomaly, or Autism Spectrum Disorder.
6. Outpatient cognitive rehabilitation therapy except as Medically Necessary following a post-traumatic brain Injury or cerebral vascular accident.
7. Psychosurgery.
8. Sex transformation operations and related services.

9. Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
10. Biofeedback except when required for pain management performed in connection with Mental Health Services and Substance Use Disorders.
11. Upper and lower jawbone surgery, orthognathic surgery, and jaw alignment. This exclusion does not apply to reconstructive jaw surgery required for Covered Persons because of a Congenital Anomaly, acute traumatic Injury, dislocation, tumors, cancer or obstructive sleep apnea. This exclusion does not apply to orthognathic surgery for which Benefits are provided as described under *Orthognathic Surgery* in *Section 1: Covered Health Services*.
12. Non-surgical treatment of obesity.
13. Breast reduction surgery except as coverage is required by the *Women's Health and Cancer Rights Act of 1998* for which Benefits are described under *Reconstructive Procedures* in *Section 1: Covered Health Services*.
14. In vitro fertilization regardless of the reason for treatment.

N. Providers

1. Services performed by a provider who is a family member by birth or marriage. Examples include a spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
2. Services performed by a provider with your same legal residence.
3. Services provided at a free-standing or Hospital-based diagnostic facility without an order written by a Physician or other provider. Services which are self-directed to a free-standing or Hospital-based diagnostic facility. Services ordered by a Physician or other provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other provider:
 - Has not been actively involved in your medical care prior to ordering the service, or
 - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography.

O. Reproduction

1. Health services and associated expenses for infertility treatments, including assisted reproductive technology, regardless of the reason for the treatment. This exclusion does not apply to services required to treat or correct underlying causes of infertility. Benefits for diagnostic testing for use in diagnosing infertility are covered the same as those for testing related to any other disease or condition.
2. Surrogate parenting, donor eggs, donor sperm and host uterus.
3. Storage and retrieval of all reproductive materials. Examples include eggs, sperm, testicular tissue and ovarian tissue.
4. The reversal of voluntary sterilization.
5. Fetal reduction surgery.
6. Health services and associated expenses for surgical, non-surgical or drug-induced Pregnancy termination. This exclusion does not apply to treatment of a molar Pregnancy, ectopic Pregnancy, missed abortion (commonly known as a miscarriage), or when the termination is performed to save the life or health of the woman having the abortion, averting impairment of a major bodily function, or when the pregnancy is the result of rape or incest.

P. Services Provided under another Plan

1. Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. Examples include coverage required by workers' compensation, no-fault auto insurance, or similar legislation.

If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, Benefits will not be paid for any Injury, Sickness or Mental Illness that would have been covered under workers' compensation or similar legislation had that coverage been elected.

2. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
3. Health services while on active military duty.

Q. Substance-Related and Addictive Disorders

In addition to all other exclusions listed in this *Section 2: Exclusions and Limitations*, the exclusions listed directly below apply to services described under *Substance-Related and Addictive Disorders Services* in *Section 1: Covered Health Services*.

1. Services performed in connection with conditions not classified in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
2. Methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents.
3. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning.
4. Substance-induced sexual dysfunction disorders and substance-induced sleep disorders.
5. Gambling disorders.
6. All unspecified disorders in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association*.
7. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - Medically Necessary.
 - Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

R. Transplants

1. Health services for organ and tissue transplants, except those described under *Transplantation Services* in *Section 1: Covered Health Services*.
2. Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person. (Donor costs that are directly related to organ removal are payable for a transplant through the organ recipient's Benefits under this Policy.)
3. Health services for transplants involving permanent mechanical or animal organs.

S. Travel

1. Health services provided in a foreign country, unless required as Emergency Health Services.

2. Travel or transportation expenses, even though prescribed by a Physician. This exclusion does not apply to the following:
 - Preauthorized Covered Health Services from a Designated Facility or Designated Physician that require a Covered Person to travel outside of the Service Area.
 - Ambulance transportation for which Benefits are provided as described under *Ambulance Services* in *Section 1: Covered Health Services*.
 - Travel expenses for transplantation services for which Benefits are provided as described under *Transplantation Services* in *Section 1: Covered Health Services*. Travel and lodging expenses are excluded if the Covered Person is a donor.

T. Types of Care

1. Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
2. Custodial Care or maintenance care.
3. Domiciliary care.
4. Private Duty Nursing or inpatient private room except when determined Medically Necessary.
5. Respite care.
6. Rest cures.
7. Services of personal care attendants.
8. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

U. Vision and Hearing

1. Purchase cost and fitting charge for eyeglasses and contact lenses. This exclusion does not apply to the first pair of contact lenses for treatment of keratoconus or post-cataract surgery. This exclusion does not apply to Vision Care Services for Covered Persons under the age of 19 for which Benefits are provided as described in the *Pediatric Vision Care Services Rider*.
2. Routine vision examinations, including refractive examinations to determine the need for vision correction. This exclusion does not apply to Vision Care Services for Covered Persons under the age of 19 for which Benefits are provided as described in the *Pediatric Vision Care Services Rider*.
3. Implantable lenses used only to correct a refractive error (such as *Intacs* corneal implants).
4. Eye exercise or vision therapy.
5. Surgery that is intended to allow you to see better without glasses or other vision correction. Examples include radial keratotomy, laser and other refractive eye surgery.
6. Bone anchored hearing aids except when either of the following applies:
 - For Covered Persons with craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid.
 - For Covered Persons with hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

More than one bone anchored hearing aid per Covered Person who meets the above coverage criteria during the entire period of time the Covered Person is enrolled under the Policy.

Repairs and/or replacement for a bone anchored hearing aid for Covered Persons who meet the above coverage criteria, other than for malfunctions.

V. All Other Exclusions

1. Health services and supplies that do not meet the definition of a Covered Health Service - see the definition in *Section 8: Defined Terms*. Covered Health Services are those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:
 - ♦ Medically Necessary.
 - ♦ Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
 - ♦ Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.
2. Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under this Policy when:
 - Required solely for purposes of school, sports or camp, travel, career or employment, insurance, marriage or adoption.
 - Related to judicial or administrative proceedings or orders.
 - Conducted for purposes of medical research. This exclusion does not apply to Covered Health Services provided during a clinical trial for which Benefits are provided as described under *Clinical Trials* in *Section 1: Covered Health Services*.
 - Required to obtain or maintain a license of any type.

Vaccinations and immunizations required as a prerequisite for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, travel, licensure, certification, registration, sports or recreational activities unless such immunizations are also considered preventive care.
3. Health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. This exclusion does not apply to Covered Persons who are civilians Injured or otherwise affected by war, any act of war, or terrorism in non-war zones.
4. Health services received after the date your coverage under this Policy ends. This applies to all health services, even if the health service is required to treat a medical condition that arose before the date your coverage under this Policy ended.
5. Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under this Policy.
6. In the event a non-Network provider waives Copayments, Coinsurance and/or any deductible for a particular health service, no Benefits are provided for the health service for which the Copayments, Coinsurance and/or deductible are waived.
7. Charges in excess of Eligible Expenses or in excess of any specified limitation.
8. Long term (more than 30 days) storage. Examples include cryopreservation of tissue, blood and blood products.
9. Autopsy, except if we choose, at our own expense, to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law.
10. Foreign language and sign language services.
11. Health services related to a non-Covered Health Service: When a service is not a Covered Health Service, all services related to that non-Covered Health Service are also excluded. This exclusion does not apply to services we would otherwise determine to be Covered Health Services if they are to treat complications that arise from the non-Covered Health Service.

For the purpose of this exclusion, a "complication" is an unexpected or unanticipated condition that is superimposed on an existing disease and that affects or modifies the prognosis of the original disease or condition. Examples of a "complication" are bleeding or infections, following a Cosmetic Procedure, that require hospitalization.

Section 3: When Coverage Begins and Premiums

How to Enroll

Eligible Persons must complete enrollment and make the required Premium payment, as determined by the Marketplace. We will not provide Benefits for health services that you receive before your effective date of coverage.

If You Are Hospitalized When Your Coverage Begins

If you are an inpatient in a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility on the day your coverage begins, we will pay Benefits for Covered Health Services that you receive on or after your first day of coverage related to that Inpatient Stay as long as you receive Covered Health Services in accordance with the terms of this Policy. These Benefits are subject to any prior carrier's obligations under state law or contract.

You should notify us of your hospitalization within 48 hours of the day your coverage begins, or as soon as is reasonably possible. Network Benefits are available only if you receive Covered Health Services from Network providers.

Who is Eligible for Coverage

The Marketplace determines who is eligible to enroll under this Policy and who qualifies as a Dependent.

Eligible Person

Eligible Person refers to a person who meets the eligibility rules established by the Marketplace. When an Eligible Person actually enrolls, we refer to that person as a Policyholder. For a complete definition of Eligible Person and Policyholder, see *Section 8: Defined Terms*.

Eligible Persons must live within the Service Area, unless otherwise provided by the Marketplace.

Dependent

Dependent generally refers to the Policyholder's spouse and children. When a Dependent actually enrolls, we refer to that person as an Enrolled Dependent. For a complete definition of Dependent and Enrolled Dependent, see *Section 8: Defined Terms*.

Dependents of an Eligible Person may not enroll unless the Eligible Person is also covered under this Policy.

When to Enroll and When Coverage Begins

Except as described below, Eligible Persons may not enroll themselves or their Dependents.

Open Enrollment Period

The open enrollment period is the period of time when Eligible Persons can enroll themselves and their Dependents, as determined by the Marketplace.

Coverage begins on the date determined by the Marketplace and identified in this Policy if we receive the completed enrollment materials and the required Premium.

Special Enrollment Period

An Eligible Person and/or Dependent may also be able to enroll during a special enrollment period, as determined by the Marketplace.

Special enrollment period means a period during which a qualified Eligible Person or Dependent who experience certain qualifying events may enroll in, or change enrollment in, a Qualified Health Plan through the Marketplace outside of the initial and annual open enrollment periods.

The Marketplace must allow an Eligible Person, and when specified below, his or her Dependent, to enroll in or change from one Qualified Health Plan to another if one of the following triggering events occurs:

- An Eligible Person or Dependent loses minimum essential coverage.
- An Eligible Person gains a Dependent or becomes a Dependent through marriage, birth, adoption, placement for adoption, or placement in foster care.
- An Eligible Person, or his or her Dependent, who was not previously a citizen, national or lawfully present, gains such status.
- An Eligible Persons' enrollment or non-enrollment in a Qualified Health Plan is unintentional, inadvertent, erroneous or is the result of an error, misrepresentation, or inaction of the Marketplace or its agents.
- An Eligible Person, or his or her Dependent, adequately demonstrates to the Marketplace that the Qualified Health Plan in which he or she is enrolled violated a material provision of its contract in relation to the Eligible Person.
- An Eligible Person, or his or her Dependent who is enrolled in the same Qualified Health Plan, is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions.
- An Eligible Person or his or her Dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan in accordance with 26 CFR 1.36B-2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage. The Marketplace must permit an individual who is enrolled in an eligible employer-sponsored plan and will lose eligibility for qualifying coverage in an eligible employer-sponsored plan within the next 60 days to access this special enrollment period prior to the end of his or her existing coverage, although he or she is not eligible for advance payments of the premium tax credit until the end of his or her coverage in an eligible employer-sponsored plan.
- An Eligible Person, or his or her Dependent, gains access to new Qualified Health Plans as a result of a permanent move.
- An Eligible Person, who is an Indian, as defined by the *Indian Health Care Improvement Act*, may enroll in a Qualified Health Plan or change from one Qualified Health Plan to another one time per month.
- An Eligible Person, or his or her Dependent, demonstrates to the Marketplace that the individual meets other exceptional circumstances as provided for by the Marketplace.

Unless specifically stated otherwise, an Eligible Person or Dependent has 60 days from the date of a triggering event to select a Qualified Health Plan.

Adding New Dependents

Policyholders may enroll Dependents only as determined by the Marketplace.

The Policyholder must notify the Marketplace of a new Dependent to be added to this Policy. The effective date of the Dependent's coverage must follow the Marketplace rules. Additional Premium may also be required, and it will be calculated from the date determined by the Marketplace.

As determined by the Marketplace, the following Dependents will be added as required under Arizona law:

- Coverage for a newborn child, adopted child or a child placed for adoption begins on the date of birth, adoption or placement for adoption and will remain in effect for 31 days. If payment of additional Premium is required in order to provide coverage for the child, the Policyholder must notify the Marketplace of the event and pay any additional required Premium within 31 days of the event in order to continue coverage beyond the initial 31-day period.

Premiums

All Premiums are payable on a monthly basis, by the Policyholder. The first Premium is due and payable on the effective date of this Policy. Subsequent Premiums are due and payable no later than the first day of the month thereafter that this Policy is in effect.

We will also accept Premium payments from the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Each Premium is to be paid by you, or a third party identified above, without contribution or reimbursement by or on behalf of any other third party including, but not limited to, any health care provider or any health care provider sponsored organization.

Premiums shall not be pro-rated based upon your effective date of coverage. A full month's Premium shall be charged for the entire month in which the Covered Person's coverage becomes effective.

Misstatement of Age or Tobacco Use

If a Covered Person's age or tobacco use status has been misstated, Benefits may be adjusted based on the relationship of the Premium paid to the Premium that should have been paid, based on the correct age or tobacco use status.

Change or Misstatement of Residence

If you change your residence, you must notify the Marketplace of your new residence. Your Premium will be based on your new residence beginning on the date determined by the Marketplace. If the change in residence results in the Policyholder no longer living in the Service Area, this Policy will terminate as described in *Section 4: When Coverage Ends*.

Grace Period

A grace period of 31 days shall be granted for the payment of any Premium, during which time coverage under this Policy shall continue in force. If payment is not received within this 31-day grace period, coverage may be canceled after the 31st day and the Policyholder shall be held liable for the cost of services received during the grace period. In no event shall the grace period extend beyond the date this Policy terminates.

We may pay Benefits for Covered Health Services incurred during this 31-day grace period. Any such Benefit payment is made in reliance on the receipt of the full Premium due from you by the end of the grace period.

However, if we pay Benefits for any claims during the grace period, and the full Premium is not paid by the end of the grace period, we will require repayment of all Benefits paid from you or any other person or organization that received payment on those claims. If repayment is due from another person or organization, you agree to assist and cooperate with us in obtaining repayment. You are responsible for repaying us if we are unsuccessful in recovering our payments from these other sources.

If you are receiving an *Advance Payment of Tax Credit*, as allowed under section 36B of title 26, as provided for by the *Patient Protection and Affordable Care Act (PPACA)*, we will pay for Covered Health Services during the 31-day grace period. You are responsible for paying the grace period Premium. If we do not receive the Premium payment by the Premium due date, you will have a three month grace period during which you may pay your Premium and keep your coverage in force. Prior to the last day of the three month grace period, we must receive all Premiums due for those three months. No claims will be paid beyond the initial 31-day grace period until all Premiums are paid for the full three month grace period.

Adjustments to Premiums

We reserve the right to change the schedule of Premiums on January 1st of each calendar year. We shall give written notice of any change in Premium to the Policyholder at least 31 days prior to the effective date of the change.

Section 4: When Coverage Ends

General Information about When Coverage Ends

We may discontinue this Policy and/or all similar policies for the reasons explained in this Policy, as permitted by law.

Your entitlement to Benefits automatically ends on the date that coverage ends, even if you are hospitalized or are otherwise receiving medical treatment on that date.

When your coverage ends, we will still pay claims for Covered Health Services that you received before the date on which your coverage ended. However, once your coverage ends, we will not pay claims for any health services received after that date (even if the medical condition that is being treated occurred before the date your coverage ended).

Unless otherwise stated, an Enrolled Dependent's coverage ends on the date the Policyholder's coverage ends.

Notice of termination of this Policy, including the reason, will be provided to you at least 30 days prior to the date of termination.

We will refund any Premium paid and not earned due to Policy termination.

This Policy may also terminate due to changes in the actuarial value requirements under state or federal law. If this Policy terminates for this reason, a new Policy, if available, may be issued to you.

You may keep coverage in force by timely payment of the required Premiums under this Policy or under any subsequent Coverage you have with us.

This Policy will renew on January 1 of each calendar year. However, we may refuse renewal if either of the following occur:

- We refuse to renew all policies issued on this form, with the same type and level of Benefits, to residents of the state where you then live, as explained under *The Entire Policy Ends* below.
- There is fraud or intentional misrepresentation made by or with the knowledge of a Covered Person in filing a claim for Benefits, as explained under *Fraud or Intentional Misrepresentation* below.

Events Ending Your Coverage

Coverage ends on the earliest of the dates specified below:

- **The Entire Policy Ends**

Your coverage ends on the date this Policy ends. That date will be one of the following:

- The date determined by the Marketplace that this Policy will terminate because the Policyholder no longer lives in the Service Area.
- The date we specify, after we give you 90 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all policies issued on this form, with the same type and level of benefits, for all residents of the state where you reside.
- The date we specify, after we give you and the applicable state authority at least 180 days prior written notice, that we will terminate this Policy because we will discontinue offering and refuse to renew all individual policies/certificates in the individual market in the state where you reside.

- **You Are No Longer Eligible**

Your coverage ends on the date you are no longer eligible to be an Enrolled Dependent, as determined by the Marketplace. Please refer to *Section 8: Defined Terms* for complete definitions of the terms "Dependent" and "Enrolled Dependent."

- **We Receive Notice to End Coverage**

Your coverage ends on the date determined by the Marketplace rules if we receive notice from the Marketplace instructing us to end your coverage.

Your coverage ends on the date determined by the Marketplace rules if we receive notice from you instructing us to end your coverage.

Other Events Ending Your Coverage

When any of the following happen, we will provide written notice to the Policyholder that coverage has ended on the date we identify in the notice:

- **Failure to Pay**

You fail to pay the required Premium.

- **Fraud or Intentional Misrepresentation of a Material Fact**

You committed an act, practice, or omission that constituted fraud, or an intentional misrepresentation of a material fact. Examples include knowingly providing incorrect information relating to another person's eligibility or status as a Dependent.

If we find that you have performed an act, practice, or omission that constitutes fraud, or have made an intentional misrepresentation of material fact we have the right to demand that you pay back all Benefits we paid to you, or paid in your name, during the time you were incorrectly covered under the Policy.

- **You Accept Reimbursement for Premium**

You accept any direct or indirect contribution or reimbursement by or on behalf of any third party including, but not limited to, any health care provider or any health care provider sponsored organization for any portion of the Premium for coverage under this Policy. This prohibition does not apply to the following third parties:

- Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act.
- Indian tribes, tribal organizations or urban Indian organizations.
- State and Federal Government programs.

Coverage for a Disabled Dependent Child

Coverage for an unmarried Enrolled Dependent child who is disabled will not end just because the child has reached a certain age. We will extend the coverage for that child beyond the limiting age if both of the following are true regarding the Enrolled Dependent child:

- Is not able to be self-supporting because of mental or physical handicap or disability.
- Depends mainly on the Policyholder for support.

Coverage will continue as long as the Enrolled Dependent is medically certified as disabled and dependent unless coverage is otherwise terminated in accordance with the terms of this Policy.

We will ask you to furnish us with proof of the medical certification of disability within 31 days of the date coverage would otherwise have ended because the child reached a certain age. Before we agree to this extension of coverage for the child, we may require that a Physician chosen by us examine the child. We will pay for that examination.

We may continue to ask you for proof that the child continues to be disabled and dependent. Such proof might include medical examinations at our expense. However, we will not ask for this information more than once a year.

If you do not provide proof of the child's disability and dependency within 31 days of our request as described above, coverage for that child will end.

Continuation of Coverage and Conversion

An Enrolled Dependent may continue coverage, other than for failure of the Policyholder to pay the required premium, under the following conditions:

- Death of the Policyholder.
- Entry of a decree of dissolution of marriage of the named Policyholder.

We have the option to continue the coverage under the existing Policy or by the issuance of a converted Policy.

Application and payment of the initial Premium must be made within 31 days after coverage ends under the Policy. Conversion coverage will be issued in accordance with the terms and conditions in effect at the time of application. Conversion coverage will provide benefits most similar to the coverage contained in the terminated Policy.

Reinstatement

When coverage under this Policy terminates for any reason, we will not reinstate coverage. You must make application for coverage under another Policy, subject to the rules of the Marketplace.

Section 5: How to File a Claim

If You Receive Covered Health Services from a Network Provider

We pay Network providers directly for your Covered Health Services. If a Network provider bills you for any Covered Health Service, contact us. However, you are responsible for meeting any applicable deductible and for paying any required Copayments and Coinsurance to a Network provider at the time of service, or when you receive a bill from the provider.

If You Receive Covered Health Services from a Non-Network Provider

When you receive a Covered Health Service from a non-Network provider, you are responsible for requesting payment from us. You must file the claim in a format that contains all of the information we require, as described below.

Notice of Claim

You should submit a request for payment of Benefits within 90 days after the date of service. If you don't provide this information to us within two years of the date of service, Benefits for that health service will be denied or reduced, as we determine. This time limit does not apply if you are legally incapacitated. If your claim relates to an Inpatient Stay, the date of service is the date your Inpatient Stay ends.

Claim Forms and Proof of Loss

We do not require that you complete and submit a claim form. Instead, you can provide proof of loss by furnishing us with all of the information listed directly below under *Required Information*.

Required Information

When you request payment of Benefits from us, you must provide us with all of the following information:

- The Policyholder's name and address.
- The patient's name and age.
- The number stated on your ID card.
- The name and address of the provider of the service(s).
- The name and address of any ordering Physician.
- A diagnosis from the Physician.
- An itemized bill from your provider that includes the *Current Procedural Terminology* (CPT) codes or a description of each charge.
- The date the Injury or Sickness began.
- A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

The above information should be filed with us at the address on your ID card. When filing a claim for Outpatient Prescription Drug Benefits, your claims should be submitted to:

Optum Rx
PO Box 29077
Hot Spring, AR 71903

Payment of Claims

We will pay Benefits immediately upon receipt of due written proof of loss.

Assignment of Benefits

You may not assign your Benefits under this Policy to a non-Network provider without our consent. When an assignment is not obtained, we will send the reimbursement directly to you (the Policyholder) for you to reimburse them upon receipt of their bill. We may, however, as we determine, pay a non-Network provider directly for services rendered to you. In the case of any such assignment of Benefits or payment to a non-Network provider, we reserve the right to offset Benefits to be paid to the provider by any amounts that the provider owes us.

When you assign your Benefits under this Policy to a non-Network provider with our consent, and the non-Network provider submits a claim for payment, you and the non-Network provider represent and warrant the following:

- The Covered Health Services were actually provided.
- The Covered Health Services were Medically Necessary.

Section 6: Questions, Complaints and Appeals

To resolve a question, complaint, or appeal, just follow these steps:

What to Do if You Have a Question

Contact *Customer Care* at the telephone number shown on your ID card. *Customer Care* representatives are available to take your call during regular business hours, Monday through Friday.

What to Do if You Have a Complaint

If you are dissatisfied with our products, services, benefits, operations or policies, you should contact our *Customer Care* Department at the telephone number or address shown on your ID card. The *Customer Care* representative will attempt to address your concern through informal discussion.

If the issue is not resolved through informal discussion, you may send a written complaint to the National Appeals Service Center at All Savers Insurance Company Appeals, P.O. Box 30573, Salt Lake City, UT 84130-0573 who will notify you of the resolution of the complaint within 30 days following its receipt. If you are dissatisfied with the resolution of the complaint, you have 30 days following the receipt of the resolution to request reconsideration of that decision in writing. However, we may be required to keep some information to your complaint confidential. Our *Customer Care* representative will contact you.

Appeals Process

You may participate in the All Savers Insurance Company's appeals process. Our appeals process is explained in detail in the All Savers Insurance Company's *Health Care Insurer Appeals Process Information Packet*. The *Health Care Insurer Appeals Process Information Packet* will be provided to you as follows:

- **Upon Initial Enrollment:** A copy of the *Health Care Insurer Appeals Process Information Packet* will be attached to your *Certificate of Coverage* upon initial enrollment.
- **When You Commence an Appeal:** The *Health Care Insurer Appeals Process Information Packet* will be provided to you within 5 business days after we receive your request for an appeal.
- **When Your Health Plan Coverage is Renewed:** When your coverage under the Policy is renewed, we will send you a separate statement with your *Certificate of Coverage* to remind you that you can request to receive another copy of the *Health Care Insurer Appeals Process Information Packet* by contacting *Customer Care* at the telephone number on the back of your ID card.

Upon Your Request or Your Treating Provider's Request: You or your treating provider may obtain a copy of the *Health Care Insurer Appeals Process Information Packet* at any time by calling *Customer Care* at the telephone number on the back of your ID card or our Appeals Department at 1-800-442-4199.

Section 7: General Legal Provisions

Your Relationship with Us

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how we interact with your Policy and how it may affect you. We administer the Policy under which you are insured. We do not provide medical services or make treatment decisions. This means:

- We communicate to you decisions about whether the Policy will cover or pay for the health care that you may receive. The plan pays for Covered Health Services, which are more fully described in this Policy.
- The Policy may not pay for all treatments you or your Physician may believe are necessary. If the Policy does not pay, you will be responsible for the cost.

We may use individually identifiable information about you to identify for you (and you alone) procedures, products or services that you may find valuable. We will use individually identifiable information about you as permitted or required by law, including in our operations and in our research. We will use de-identified data for commercial purposes including research.

Please refer to our *Notice of Privacy Practices* for details.

Our Relationship with Providers

The relationships between us and Network providers are solely contractual relationships between independent contractors. Network providers are not our agents or employees. Neither we nor any of our employees are agents or employees of Network providers.

We do not provide health care services or supplies, nor do we practice medicine. Instead, we arrange for health care providers to participate in a Network and we pay Benefits. Network providers are independent practitioners who run their own offices and facilities. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided. They are not our employees nor do we have any other relationship with Network providers such as principal-agent or joint venture. We are not liable for any act or omission of any provider.

Your Relationship with Providers

The relationship between you and any provider is that of provider and patient.

- You are responsible for choosing your own provider.
- You are responsible for paying, directly to your provider, any amount identified as a member responsibility, including Copayments, Coinsurance, any deductible and any amount that exceeds Eligible Expenses.
- You are responsible for paying, directly to your provider, the cost of any non-Covered Health Service.
- You must decide if any provider treating you is right for you. This includes Network providers you choose and providers to whom you have been referred.
- You must decide with your provider what care you should receive.
- Your provider is solely responsible for the quality of the services provided to you.

Incentives to Providers

We pay Network providers through various types of contractual arrangements, some of which may include financial incentives to promote the delivery of health care in a cost efficient and effective manner. These financial incentives are not intended to affect your access to health care.

Examples of financial incentives for Network providers are:

- Bonuses for performance based on factors that may include quality, member satisfaction and/or cost-effectiveness.
- Capitation - a group of Network providers receives a monthly payment from us for each Covered Person who selects a Network provider within the group to perform or coordinate certain health services. The Network providers receive this monthly payment regardless of whether the cost of providing or arranging to provide the Covered Person's health care is less than or more than the payment.

We use various payment methods to pay specific Network providers. From time to time, the payment method may change. If you have questions about whether your Network provider's contract with us includes any financial incentives, we encourage you to discuss those questions with your provider. You may also contact us at the telephone number on your ID card. We can advise whether your Network provider is paid by any financial incentive, including those listed above; however, the specific terms of the contract, including rates of payment, are confidential and cannot be disclosed.

Incentives to You

Sometimes we may offer coupons or other incentives to encourage you to participate in various wellness programs or certain disease management programs. The decision about whether or not to participate is yours alone but we recommend that you discuss participating in such programs with your Physician. These incentives are not Benefits and do not alter or affect your Benefits. Contact us if you have any questions.

Rebates and Other Payments

We may receive rebates for certain drugs that are administered to you in your home or in a Physician's office, or at a Hospital or Alternate Facility. This includes rebates for those drugs that are administered to you before you meet any applicable deductible. We do not pass these rebates on to you, nor are they applied to any deductible or taken into account in determining your Copayments or Coinsurance.

Interpretation of Benefits

We have the sole and exclusive authority to do all of the following:

- Interpret Benefits under this Policy.
- Interpret the other terms, conditions, limitations and exclusions set out in this Policy, including the *Schedule of Benefits* and any Riders and/or Amendments.
- Make factual determinations related to this Policy and its Benefits.

We may delegate this authority to other persons or entities that provide services in regard to the administration of this Policy.

In certain circumstances, for purposes of overall cost savings or efficiency, we may, as we determine, offer Benefits for services that would otherwise not be Covered Health Services. The fact that we do so in any particular case shall not in any way be deemed to require us to do so in other similar cases.

Administrative Services

We may, as we determine, arrange for various persons or entities to provide administrative services in regard to this Policy, such as claims processing. The identity of the service providers and the nature of the services they provide may be changed from time to time, as we determine. We are not required to give you prior notice of any such change, nor are we required to obtain your approval. You must cooperate with those persons or entities in the performance of their responsibilities.

Amendments to this Policy

To the extent permitted by law, we reserve the right to change, interpret, modify, withdraw or add Benefits or terminate this Policy. We will provide the Policyholder with 60 days prior notice of changes to the Policy that would be effective on the anniversary date of the Policy.

Any provision of this Policy which, on its effective date, is in conflict with the requirements of state or federal statutes or regulations (of the jurisdiction in which this Policy is delivered) is hereby amended to conform to the minimum requirements of such statutes and regulations.

No other change may be made to this Policy unless it is made by an Amendment or Rider which has been signed by one of our officers. All of the following conditions apply:

- Amendments are effective after we send written notice to the Policyholder as described above.
- Riders are effective on the date we specify.
- No agent has the authority to change this Policy or to waive any of its provisions.
- No one has authority to make any oral changes or amendments to this Policy.

Information and Records

We may use your individually identifiable health information to administer this Policy and pay claims, to identify procedures, products, or services that you may find valuable, and as otherwise permitted or required by law. We may request additional information from you to decide your claim for Benefits. We will keep this information confidential. We may also use your de-identified data for commercial purposes, including research, as permitted by law. More detail about how we may use or disclose your information is found in our *Notice of Privacy Practices*.

By accepting Benefits under this Policy, you authorize and direct any person or institution that has provided services to you to furnish us with all information or copies of records relating to the services provided to you. We have the right to request this information at any reasonable time. This applies to all Covered Persons, including Enrolled Dependents whether or not they have signed the Policyholder's enrollment form. We agree that such information and records will be considered confidential.

We have the right to release any and all records concerning health care services which are necessary to implement and administer the terms of this Policy, for appropriate medical review or quality assessment, or as we are required to do by law or regulation. During and after the term of this Policy, we and our related entities may use and transfer the information gathered under this Policy in a de-identified format for commercial purposes, including research and analytic purposes. Please refer to our Notice of Privacy Practices.

For complete listings of your medical records or billing statements we recommend that you contact your health care provider. Providers may charge you reasonable fees to cover their costs for providing records or completing requested forms.

If you request medical forms or records from us, we also may charge you reasonable fees to cover costs for completing the forms or providing the records.

In some cases, as permitted by law, we will designate other persons or entities to request records or information from or related to you, and to release those records as necessary. Our designees have the same rights to this information as we have.

Time Limit on Certain Defenses

No misstatement made by the Policyholder, except fraudulent misstatements made by the applicant in the application, can be used to void this Policy after it has been in force for a period of two years.

Examination of Covered Persons

In the event of a question or dispute regarding your right to Benefits, we may require that a Network Physician of our choice examine you at our expense.

Workers' Compensation not Affected

Benefits provided under this Policy do not substitute for and do not affect any requirements for coverage by workers' compensation insurance.

Refund of Overpayments

If we pay Benefits for expenses incurred on account of a Covered Person, that Covered Person, or any other person or organization that was paid, must make a refund to us if any of the following apply:

- All or some of the expenses were not paid by the Covered Person or did not legally have to be paid by the Covered Person.
- All or some of the payment we made exceeded the Benefits under this Policy.
- All or some of the payment was made in error.

The refund equals the amount we paid in excess of the amount we should have paid under this Policy. If the refund is due from another person or organization, the Covered Person agrees to help us get the refund when requested.

If the Covered Person, or any other person or organization that was paid, does not promptly refund the full amount, we may reduce the amount of any future Benefits for the Covered Person that are payable under this Policy. The reductions will equal the amount of the required refund. We may have other rights in addition to the right to reduce future benefits.

Important Notice - Third Party Payers

When there is a third party source of payment such as liability insurer, a government payer, or any uninsured and/or underinsured motorist coverage, Network providers may be entitled to collect from the third parties. They may be entitled to collect any difference between Eligible Expenses that we pay and the Network providers' customary charges, pursuant to A.R.S. 33-931. Arizona law prohibits providers from charging you more than the Copayment and any deductible you are required to pay as described in this Policy.

Limitation of Action

You cannot bring any legal action against us to recover reimbursement until 60 days after you have properly submitted a request for reimbursement as described in *Section 5: How to File a Claim*. In the interest of saving time and money, you are encouraged to first complete all steps in the appeal process described in *Section 6: Questions, Complaints and Appeals*.

If you want to bring a legal action against us you must do so within three years from the applicable date specified below or you lose any rights to bring such an action against us:

- The date of expiration of the time period in which a request for reimbursement must be submitted.
- The date we notified you of our final decision on your appeal.

Entire Policy

This Policy, including the *Schedule of Benefits*, the Policyholder's application and any Riders and/or Amendments, constitutes the entire Policy.

Section 8: Defined Terms

Alternate Facility - a health care facility that is not a Hospital and that provides one or more of the following services on an outpatient basis, as permitted by law:

- Deliveries in a Birthing Center.
- Surgical services.
- Emergency Health Services.
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An Alternate Facility may also provide Mental Health Services or Substance-Related and Addictive Disorders Services on an outpatient or inpatient basis.

Amendment - any attached written description of additional or alternative provisions to this Policy. Amendments are effective only when signed by us. Amendments are subject to all conditions, limitations and exclusions of this Policy, except for those that are specifically amended.

Annual Deductible - this is the amount of Eligible Expenses you must pay for Covered Health Services per year before we will begin paying for Benefits. The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Refer to the *Schedule of Benefits* for details about how the Annual Deductible applies.

Autism Spectrum Disorder - a condition marked by enduring problems communicating and interacting with others, along with restricted and repetitive behavior, interests or activities.

Behavioral Therapy - interactive therapies derived from evidence based research, including applied behavior analysis, which includes discrete trial training, pivotal response training, intensive intervention programs and early intensive behavioral intervention.

Benefits - your right to payment for Covered Health Services that are available under this Policy. Your right to Benefits is subject to the terms, conditions, limitations and exclusions of this Policy, including the *Schedule of Benefits* and any attached Riders and/or Amendments.

Birthing Center a licensed outpatient facility which provides accommodations for childbirth for low-risk maternity patients. The birthing center must meet all of the following criteria:

- Has an organized staff of certified midwives, physicians, and other trained personnel;
- Has necessary medical equipment;
- Has a written agreement to transfer to a hospital if necessary; and
- Is in compliance with any applicable state or local regulations.

Coinurance - the charge, stated as a percentage of Eligible Expenses, that you are required to pay for certain Covered Health Services.

Congenital Anomaly - a physical developmental defect that is present at the time of birth, and that is identified within the first twelve months of birth.

Copayment - the charge, stated as a set dollar amount, that you are required to pay for certain Covered Health Services.

Please note that for Covered Health Services, you are responsible for paying the lesser of the following:

- The applicable Copayment.
- The Eligible Expense.

Cosmetic Procedures - procedures or services that change or improve appearance without significantly improving physiological function, as determined by us.

Covered Health Service(s) - those health services, including services, supplies, or Pharmaceutical Products, which we determine to be all of the following:

- Medically Necessary.
- Described as a Covered Health Service in this Policy under *Section 1: Covered Health Services* and in the *Schedule of Benefits*.
- Not otherwise excluded in this Policy under *Section 2: Exclusions and Limitations*.

Covered Person - either the Policyholder or an Enrolled Dependent, but this term applies only while the person is enrolled under this Policy. References to "you" and "your" throughout this Policy are references to a Covered Person.

Custodial Care - services that are any of the following:

- Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
- Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
- Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Dependent - the Policyholder's legal spouse or a child of the Policyholder or the Policyholder's spouse. The term child includes any of the following:

- A natural child.
- A stepchild.
- A legally adopted child.
- A child placed for adoption.
- A child for whom legal guardianship has been awarded to the Policyholder or the Policyholder's spouse.

The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any child listed above under 26 years of age.
- A Dependent includes an unmarried dependent child age 26 or older who is or becomes disabled and dependent upon the Policyholder.

The Policyholder must reimburse us for any Benefits that we pay for a child at a time when the child did not satisfy these conditions.

Designated Dispensing Entity - a pharmacy or other provider that has entered into an agreement with us, or with an organization contracting on our behalf, to provide Pharmaceutical Products for the treatment of specified diseases or conditions. The fact that a pharmacy or other provider is a Network provider does not mean that it is a Designated Dispensing Entity.

Designated Facility - a facility that has entered into an agreement with us, or with an organization contracting on our behalf, to render Covered Health Services for the treatment of specified diseases or conditions. A Designated Facility may or may not be located within the Service Area. The fact that a Hospital is a Network Hospital does not mean that it is a Designated Facility.

Designated Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by a Physician or other provider that we have identified as Designated Network providers. Refer to the *Schedule of Benefits* for details about how Designated Network Benefits apply.

Designated Physician - a Physician that we've identified through our designation programs as a Designated provider. A Designated Physician may or may not be located within the Service Area. The fact that a Physician is a Network Physician does not mean that he or she is a Designated Physician.

Designated Virtual Network Provider - a provider or facility that has entered into an agreement with us, or with an organization contracting on our behalf, to deliver Covered Health Services via interactive audio and video modalities.

Durable Medical Equipment - medical equipment that is all of the following:

- Can withstand repeated use.
- Is not disposable.
- Is used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms.
- Is generally not useful to a person in the absence of a Sickness, Injury or their symptoms.
- Is appropriate for use in the home.
- Is not implantable within the body.

Eligible Expenses - for Covered Health Services, incurred while this Policy is in effect, Eligible Expenses are determined by us as stated below and as detailed in the *Schedule of Benefits*.

Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines. We develop our reimbursement policy guidelines, as we determine, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the *Current Procedural Terminology (CPT)*, a publication of the *American Medical Association*, and/or the *Centers for Medicare and Medicaid Services (CMS)*.
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate source or determination that we accept.

Eligible Person - a person who meets the eligibility requirements determined by the Marketplace. An Eligible Person must live within the Service Area.

Emergency - a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Serious jeopardy to the patient's health.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Health Services - health care services and supplies necessary for the treatment of an Emergency. Emergency Health Services do not require prior authorization.

Enrolled Dependent - a Dependent who is properly enrolled under this Policy.

Experimental or Investigational Service(s) - medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders, or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time we make a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the *U.S. Food and Drug Administration (FDA)* to be lawfully marketed for the proposed use and not identified in the *American Hospital Formulary Service* or the *United States Pharmacopoeia Dispensing Information* as appropriate for the proposed use.

- Subject to review and approval by any institutional review board for the proposed use. (Devices which are *FDA* approved under the *Humanitarian Use Device* exemption are not considered to be Experimental or Investigational.)
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III clinical trial set forth in the *FDA* regulations, regardless of whether the trial is actually subject to *FDA* oversight.

Exceptions:

- Clinical trials for which Benefits are available as described under *Clinical Trials* in *Section 1: Covered Health Services*.
- If you are not a participant in a qualifying clinical trial, as described under *Clinical Trials* in *Section 1: Covered Health Services*, and have a Sickness or condition that is likely to cause death within one year of the request for treatment we may, as we determine, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.
- This exclusion will not apply to drugs prescribed for the treatment of cancer if the drug has been recognized by the *Food and Drug Administration* as safe and effective for treatment of that specific type of cancer in one or more of the following acceptable standard medical reference compendia, or in medical literature listed below:
 - The acceptable standard medical reference compendia are the following:
 - ♦ The *American Hospital Formulary Service Drug Information*, a publication of the *American Society of Health System Pharmacists*.
 - ♦ The *National Comprehensive Cancer Network Drugs and Biologics Compendium*.
 - ♦ *Thomson Micromedex Compendium DRUGDEX*.
 - ♦ *Elsevier Gold Standard's Clinical Pharmacology Compendium*.
 - ♦ Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services*.
 - Medical literature may be accepted if all of the following apply:
 - ♦ At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
 - ♦ No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
 - ♦ The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors*, or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant to Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B)).

Genetic Testing - examination of blood or other tissue for chromosomal and DNA abnormalities and alterations, or other expressions of gene abnormalities that may indicate an increased risk for developing a specific disease or disorder.

Home Health Agency - a program or organization authorized by law to provide health care services in the home.

Hospital - an institution that is operated as required by law and that meets both of the following:

- It is primarily engaged in providing health services, on an inpatient basis, for the acute care and treatment of injured or sick individuals. Care is provided through medical, diagnostic and surgical facilities, by or under the supervision of a staff of Physicians.
- It has 24-hour nursing services.

A Hospital is not primarily a place for rest, Custodial Care or care of the aged and is not a nursing home, convalescent home or similar institution. A Hospital is not a skilled nursing facility or an inpatient rehabilitation facility.

Injury - bodily damage other than Sickness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility - a long term acute rehabilitation center, a Hospital (or a special unit of a Hospital designated as an Inpatient Rehabilitation Facility) that provides rehabilitation health services (including physical therapy, occupational therapy and/or speech therapy) on an inpatient basis, as authorized by law.

Inpatient Stay - an uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

Intensive Outpatient Treatment - a structured outpatient mental health or substance-related and addictive disorders treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care - skilled nursing care that is provided or needed either:

- Fewer than seven days each week.
- Fewer than eight hours each day for periods of 21 days or less.

Exceptions may be made in exceptional circumstances when the need for additional care is finite and predictable.

Manipulative Treatment - the nonsurgical and noninvasive treatment of neck and back pain through physiotherapy, musculoskeletal manipulation and other physical corrections of musculoskeletal conditions within the scope of the chiropractic practice.

Medically Necessary - health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by us or our designee.

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for your convenience or that of your doctor or other health care provider.
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. We reserve the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to

apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by us.

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline.

Medicare - Parts A, B, C and D of the insurance program established by Title XVIII, *United States Social Security Act*, as amended by 42 U.S.C. Sections 1394, et seq. and as later amended.

Mental Health Services - Covered Health Services for the diagnosis and treatment of Mental Illnesses. The fact that a condition is listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment for the condition is a Covered Health Service.

Mental Health/Substance-Related and Addictive Disorders Designee - the organization or individual, designated by us, that provides or arranges Mental Health Services and Substance-Related and Addictive Disorders Services for which Benefits are available under this Policy.

Mental Illness - those mental health or psychiatric diagnostic categories that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded under this Policy.

Network - when used to describe a provider of health care services, this means a provider that has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network; however, this does not include those providers who have agreed to discount their charges for Covered Health Services. Our affiliates are those entities affiliated with us through common ownership or control with us or with our ultimate corporate parent, including direct and indirect subsidiaries.

A provider may enter into an agreement to provide only certain Covered Health Services, but not all Covered Health Services, or to be a Network provider for only some of our products. In this case, the provider will be a Network provider for the Covered Health Services and products included in the participation agreement, and a non-Network provider for other Covered Health Services and products. The participation status of providers will change from time to time.

Network Area – the Service Area, supplemented by any additional providers we include as Network Area providers. Go to www.myuhc.com or contact *Customer Care* for additional information on the Network Area.

Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by Network providers. Refer to the *Schedule of Benefits* for details about how Network Benefits apply.

Network Physician - a Physician, as defined in *Section 8: Defined Terms*, who has a participation agreement in effect (either directly or indirectly) with us or with our affiliate to participate in our Network.

Non-Network Benefits - this is the description of how Benefits are paid for Covered Health Services provided by non-Network providers. Refer to the *Schedule of Benefits* for details about how Non-Network Benefits apply.

Out-of-Pocket Maximum - the maximum amount of Eligible Expenses you pay every year for Covered Health Services. Refer to the *Schedule of Benefits* for details about how the Out-of-Pocket Maximum applies.

Partial Hospitalization/Day Treatment - a structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

Per Occurrence Deductible - this is the amount of Eligible Expenses (stated as a set dollar amount) that you must pay for certain Covered Health Services prior to and in addition to any Annual Deductible before we will begin paying for Benefits for those Covered Health Services.

You are responsible for paying the lesser of the following:

- The applicable Per Occurrence Deductible.
- The Eligible Expense.

Refer to the *Schedule of Benefits* for details about the specific Covered Health Services to which the Per Occurrence Deductible applies.

Pharmaceutical Product(s) - U.S. Food and Drug Administration (FDA)-approved prescription pharmaceutical products administered in connection with a Covered Health Service by a Physician or other health care provider within the scope of the provider's license, and not otherwise excluded under this Policy.

Physician - any provider who is properly licensed and qualified by law to provide services that are within the lawful scope of practice of Physician (as defined by Arizona law).

Please Note: Any podiatrist, dentist, psychologist, chiropractor, optometrist, or other provider who acts within the scope of his or her license will be considered on the same basis as a Physician. The fact that we describe a provider as a Physician does not mean that Benefits for services from that provider are available to you under this Policy.

Policy - the entire agreement that includes all of the following:

- This Policy.
- The *Schedule of Benefits*.
- The Policyholder's application.
- Riders.
- Amendments.

These documents make up the entire agreement that is issued to the Policyholder.

Policyholder - the person (who is not a Dependent) to whom this Policy is issued.

Pregnancy - includes all of the following:

- Prenatal care.
- Postnatal care.
- Childbirth.
- Any complications associated with Pregnancy.

Premium - the periodic fee required for each Policyholder and each Enrolled Dependent, in accordance with the terms of this Policy.

Primary Physician - a Physician who has a majority of his or her practice in general pediatrics, internal medicine, family practice or general medicine.

Private Duty Nursing - services that are provided in a patient's residence from a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), in accordance with a physician's care plan. Private duty nursing services are provided by a licensed home care agency that is prescribed on an intermittent basis. Private Duty Nursing is available only in an inpatient setting when skilled nursing is not available from the facility. Custodial nursing is not covered.

Private Room - a hospital room containing one bed.

Psychiatric Services - psychotherapy and other accepted forms for evaluation, diagnosis, or treatment of mental or emotional disorders. Psychiatric Services include individual, group and family psychotherapy; electroshock and other convulsive therapy; psychological testing; psychiatric consultations; and any other forms of psychotherapeutic treatment as determined to be Medically Necessary.

Qualified Health Plan Issuer - a health insurance issuer that offers a *Qualified Health Plan* in accordance with a certification from the Marketplace.

Residential Treatment Facility - a facility which provides a program of Mental Health Services or Substance-Related and Addictive Disorders Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a Physician and approved by the Mental Health/Substance-Related and Addictive Disorders Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A Residential Treatment Facility that qualifies as a Hospital is considered a Hospital.

Rider - any attached written description of additional Covered Health Services not described in this Policy. Covered Health Services provided by a Rider may be subject to payment of additional Premiums. Note that Benefits for Outpatient Prescription Drugs, Pediatric Vision Care Services and Pediatric Dental Services, while presented in Rider format, are not subject to payment of additional Premiums and are included in the overall Premium for Benefits under this Policy. Riders are effective only when signed by us and are subject to all conditions, limitations and exclusions of this Policy except for those that are specifically amended in the Rider.

Semi-private Room - a room with two or more beds. When an Inpatient Stay in a Semi-private Room is a Covered Health Service, the difference in cost between a Semi-private Room and a private room is a Benefit only when a private room is necessary in terms of generally accepted medical practice, or when a Semi-private Room is not available.

Service Area - the geographic area where we act as a Qualified Health Plan Issuer as approved by the appropriate regulatory agency. Contact us to determine the exact geographic area we serve. The Service Area may change from time to time.

Skilled Nursing Facility - a Hospital or nursing facility that is licensed and operated as required by law.

Sickness - physical illness, disease or Pregnancy. The term Sickness as used in this Policy includes Mental Illness and substance-related and addictive disorders, regardless of the cause or origin of the Mental Illness or substance-related and addictive disorders.

Specialist Physician - a Physician who has a majority of his or her practice in areas other than general pediatrics, internal medicine, family practice or general medicine.

Substance-Related and Addictive Disorders Services - Covered Health Services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*, unless those services are specifically excluded. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Health Service.

Transitional Care - Mental Health Services and Substance-Related and Addictive Disorders Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug-

free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to treatment when treatment doesn't offer the intensity and structure needed to assist the Covered Person with recovery.

Unproven Service(s) - services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies from more than one institution. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

We have a process by which we compile and review clinical evidence with respect to certain health services. From time to time, we issue medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice. You can view these policies at www.myuhc.com.

Please note:

- If you have a life-threatening Sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, as we determine, consider an otherwise Unproven Service to be a Covered Health Service for that Sickness or condition. Prior to such a consideration, we must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that Sickness or condition.

Urgent Care Center - a facility that provides Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

All Savers Insurance Company

Compass Plus

Individual Medical Policy

Schedule of Benefits

Gold Compass Plus 0

Note: American Indian Plans (Limited Cost Share)

American Indian benefits plans are available to members of federally recognized tribes. American Indians with incomes above 300% of the federal poverty level may enroll in limited cost sharing plans. If you enroll through the Marketplace, you may receive Covered Health Care Services from the Indian Health Service, tribal health programs, or urban Indian health programs or you may access covered services as described below under *Accessing Benefits*.

Selecting a Primary Physician

You must select a Primary Physician in order to obtain Network Benefits. In general health care terminology, a Primary Physician may also be referred to as a *Primary Care Physician* or *PCP*. A Primary Physician will be able to coordinate all Covered Health Services and make referrals for services from Network Physicians. If you are the custodial parent of an Enrolled Dependent child, you must select a Primary Physician for that child. If you do not select a Primary Physician, one will be assigned to you.

You may select any Network Primary Physician who is accepting new patients. You may designate a pediatrician as the Primary Physician for an Enrolled Dependent child. For obstetrical or gynecological care, you do not need a referral from a Primary Physician and may seek care directly from any Network obstetrician or gynecologist. You do not need a referral from a Primary Physician to obtain Medically Necessary Manipulative Treatment from a Network chiropractic provider. You do not need a referral from a Primary Physician to obtain Medically Necessary occupational or physical therapy services from a non-Network occupational therapist or physical therapist.

You can obtain a list of Network Primary Physicians and/or Network obstetricians and gynecologists by going to www.myuhc.com or by calling *Customer Care* at the telephone number on your identification (ID) card.

You may change your Primary Physician by contacting *Customer Care* at the telephone number shown on your ID card. Changes are permitted once per month. Changes submitted on or before the 15th of the month will be effective on the first day of the following month. Changes submitted on or after the 16th of the month will be effective on the first day of the second following month.

Accessing Benefits

You can choose to receive Network Benefits or Non-Network Benefits as follows:

- A higher level of Network Benefits is provided when Covered Health Services are provided by or referred by your Primary Physician. If care from another Network Physician is needed, your Primary Physician will provide you with a referral. The referral must be received before the services are rendered.
- If you see a Network Physician without a referral from your Primary Physician, you may receive a lower level of Network Benefits, regardless of the place of service. This lower level of Benefits will

apply to all related services and facility charges received without the required referral. For obstetrical or gynecological care, you do not need a referral from a Primary Physician and may seek care directly from any Network obstetrician or gynecologist. You do not need a referral from a Primary Physician to obtain Medically Necessary Manipulative Treatment from a Network chiropractic provider. You do not need a referral from a Primary Physician to obtain Medically Necessary occupational or physical therapy services from a non-Network occupational therapist or physical therapist.

- Non-Network Benefits are also available for services from non-network physicians, facilities and health care professionals at a lower level of benefits than either level of benefits for network providers.

Compass Plus offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a Compass Plus Network provider within the Network Area. You can confirm that your provider is a Compass Plus Network provider by calling *Customer Care* at the telephone number on your ID card or you can access a directory of providers online at www.myuhc.com. You should confirm that your provider is a UnitedHealthcare Compass Plus Network provider, including when receiving Covered Health Services for which you received a referral from your Primary Physician.

Emergency Health Services provided by a non-Network provider will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network providers for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Covered Health Services that are provided at a Network facility within the Network Area by a non-Network facility based Physician, when not Emergency Health Services, will be reimbursed as set forth under *Eligible Expenses* as described at the end of this *Schedule of Benefits*. **As a result, you will be responsible for the difference between the amount billed by the non-Network facility based Physician and the amount we determine to be an Eligible Expense for reimbursement. The payments you make to non-Network facility based Physicians for charges above the Eligible Expense do not apply towards any applicable Out-of-Pocket Maximum.**

Non-Network Benefits apply to Covered Health Services that are provided by a non-Network Physician or other non-Network provider, or Covered Health Services that are provided at a non-Network facility. In general health care terminology, Non-Network Benefits may also be referred to as *Out-of-Network Benefits*.

You must show your identification card (ID card) every time you request health care services from a Network provider. If you do not show your ID card, Network providers have no way of knowing that you are enrolled under an All Savers Insurance Company Policy. As a result, they may bill you for the entire cost of the services you receive.

Additional information about the network of providers and how your Benefits may be affected appears at the end of this *Schedule of Benefits*.

If there is a conflict between this *Schedule of Benefits* and any summaries provided to you, this *Schedule of Benefits* will control.

Prior Authorization

We require prior authorization for certain Covered Health Services. In general, your Primary Physician and other Network providers are responsible for obtaining prior authorization before they provide these services to you. There are some Network Benefits, however, for which you are responsible for obtaining prior authorization. Services for which you are required to obtain prior authorization are identified below and in the *Schedule of Benefits* table within each Covered Health Service category.

Please note that prior authorization is required even if you have a referral from your Primary Physician to seek care from another Network Physician.

We recommend that you confirm with us that all Covered Health Services listed below have been prior authorized as required. Before receiving these services from a Network provider, you may want to contact us to verify that the Hospital, Physician and other providers are Network providers and that they have obtained the required prior authorization. Network facilities and Network providers cannot bill you for services they fail to prior authorize as required. You can contact us by calling the telephone number for *Customer Care* on your ID card.

When you choose to receive certain Covered Health Services from non-Network providers, you are responsible for obtaining prior authorization before you receive these services. Note that your obligation to obtain prior authorization is also applicable when a non-Network provider intends to admit you to a Network facility or refers you to other Network providers. Once you have obtained the authorization, please review it carefully so that you understand what services have been authorized and what providers are authorized to deliver the services that are subject to the authorization.

To obtain prior authorization, call the telephone number for *Customer Care* on your ID card. This call starts the utilization review process.

The utilization review process is a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, retrospective review or similar programs.

Covered Health Services which Require Prior Authorization

Please note that prior authorization timelines apply. Refer to the applicable Benefit description in the *Schedule of Benefits* table to determine how far in advance you must obtain prior authorization.

- Ambulance - non-emergent air, ground and water vehicles.
- Clinical trials.
- Dental services - accident.
- Dental services - Hospital or Alternative Facility/anesthesia.
- Diabetes equipment - insulin pumps over \$1,000.
- Durable Medical Equipment over \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item).
- Genetic Testing - BRCA.
- Habilitative Services.
- Hearing Aids that exceed \$1,000 in retail cost.
- Home health care.
- Hospice care - inpatient.
- Hospital inpatient care - all scheduled admissions and maternity stays exceeding 48 hours for normal vaginal delivery or 96 hours for a cesarean section delivery.
- Lab, X-ray and diagnostics - sleep studies.
- Lab, X-ray and major diagnostics - CT, PET Scans, MRI, MRA, BEAM, ECT, Nuclear Medicine and Capsule Endoscopy.
- Manipulative Treatment.
- Mental Health Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; outpatient

electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.

- Neurodevelopmental disorders - Autism Spectrum Disorder services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility), Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Behavioral Therapy.
- Obesity surgery.
- Orthognathic surgery.
- Prosthetic devices over \$1,000 in cost per device.
- Reconstructive procedures, including breast reconstruction surgery following mastectomy.
- Rehabilitation services - physical therapy, occupational therapy and speech therapy.
- Skilled Nursing Facility and Inpatient Rehabilitation Facility services.
- Substance-Related and Addictive Disorders Services - inpatient services (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility); Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.
- Surgery - only for the following outpatient surgeries: cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization, electrophysiology implant and sleep apnea surgeries.
- Telemedicine services.
- Temporomandibular joint services.
- Therapeutics - only for the following services: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound.
- Transplants.
- Vision Correction after Surgery.

For all other services, when you choose to receive services from non-Network providers, we urge you to confirm with us that the services you plan to receive are Covered Health Services. That's because in some instances, certain procedures may not be Medically Necessary or may not otherwise meet the definition of a Covered Health Service, and therefore are excluded. In other instances, the same procedure may meet the definition of Covered Health Services. By calling before you receive treatment, you can check to see if the service is subject to limitations or exclusions.

If you request a coverage determination at the time prior authorization is provided, the determination will be made based on the services you report you will be receiving. If the reported services differ from those actually received, our final coverage determination will be modified to account for those differences, and we will only pay Benefits based on the services actually delivered to you.

If you choose to receive a service that has been determined not to be a Medically Necessary Covered Health Service, you will be responsible for paying all charges and no Benefits will be paid.

Care Management

When you seek prior authorization as required, we will work with you to implement the care management process and to provide you with information about additional services that are available to you, such as disease management programs, health education, and patient advocacy.

Benefits

Annual Deductibles are calculated on a calendar year basis.

Out-of-Pocket Maximums are calculated on a calendar year basis.

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Payment Term And Description	Amounts
Annual Deductible	
<p>The amount of Eligible Expenses you pay for Covered Health Services per year before you are eligible to receive Benefits.</p> <p>Amounts paid toward the Annual Deductible for Covered Health Services that are subject to a visit or day limit will also be calculated against that maximum Benefit limit. As a result, the limited Benefit will be reduced by the number of days/visits used toward meeting the Annual Deductible.</p> <p>The amount that is applied to the Annual Deductible is calculated on the basis of Eligible Expenses. The Annual Deductible does not include any amount that exceeds Eligible Expenses. Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Annual Deductible does not include any applicable Per Occurrence Deductible.</p>	<p><i>Network</i></p> <p>\$0 per Covered Person, not to exceed \$0 for all Covered Persons in a family.</p> <p><i>Non-Network</i></p> <p>\$1,000 per Covered Person, not to exceed \$2,000 for all Covered Persons in a family.</p>
Per Occurrence Deductible	
<p>The amount of Eligible Expenses stated as a set dollar amount that you must pay for certain Covered Health Services (prior to and in addition to any Annual Deductible) before we will begin paying for Benefits for those Covered Health Services.</p> <p>You are responsible for paying the lesser of the following:</p> <ul style="list-style-type: none"> • The applicable Per Occurrence Deductible. • The Eligible Expense. 	<p>When a Per Occurrence Deductible applies, it is listed below under each Covered Health Service category.</p>
Out-of-Pocket Maximum	

Payment Term And Description	Amounts
<p>The maximum you pay per year for the Annual Deductible, the Per Occurrence Deductible, Copayments and Coinsurance. Once you reach the Out-of-Pocket Maximum, Benefits are payable at 100% of Eligible Expenses during the rest of that year. The Out-of-Pocket Maximum applies to Covered Health Services under the Policy as indicated in this <i>Schedule of Benefits</i>, including Covered Health Services provided under the <i>Outpatient Prescription Drug Rider</i> and the <i>Pediatric Vision Care Services Rider</i> and the <i>Pediatric Dental Services Rider</i>.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p> <p>The Out-of-Pocket Maximum does not include any of the following and, once the Out-of-Pocket Maximum has been reached, you still will be required to pay the following:</p> <ul style="list-style-type: none"> • Any charges for non-Covered Health Services. • The amount Benefits are reduced if you do not obtain prior authorization or a referral as required. • Charges that exceed Eligible Expenses. 	<p><i>Network</i></p> <p>\$6,,850 per Covered Person, not to exceed \$13,700 for all Covered Persons in a family.</p> <p><i>Non-Network</i></p> <p>No Out-of-Pocket Maximum.</p>
Copayment	
<p>Copayment is the amount you pay (calculated as a set dollar amount) each time you receive certain Covered Health Services. When Copayments apply, the amount is listed on the following pages next to the description for each Covered Health Service.</p> <p>Please note that for Covered Health Services, you are responsible for paying the lesser of:</p> <ul style="list-style-type: none"> • The applicable Copayment. • The Eligible Expense. <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	
Coinsurance	
<p>Coinsurance is the amount you pay (calculated as a percentage of Eligible Expenses) each time you receive certain Covered Health Services.</p> <p>Details about the way in which Eligible Expenses are determined appear at the end of the <i>Schedule of Benefits</i> table.</p>	

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
1. Ambulance Services			
<p align="center">Prior Authorization Requirement</p> <p>In most cases, we will initiate and direct non-Emergency ambulance transportation. If you are requesting non-Emergency ambulance services, you must obtain authorization as soon as possible prior to transport. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
<p>Emergency Ambulance Ground, water or air ambulance.</p> <p>Non-Emergency Ambulance Ground, water or air ambulance.</p>	<p><i>Network</i> <i>Ground Ambulance:</i> 70% <i>Air Ambulance:</i> 70% <i>Water Ambulance:</i> 70% <i>Non-Network</i> Same as Network</p> <p><i>Network</i> <i>Ground Ambulance:</i> 70% <i>Air Ambulance:</i> 70% <i>Water Ambulance:</i> 70% <i>Non-Network</i> Same as Network</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Same as Network</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Same as Network</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Same as Network</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Same as Network</p>
2. Clinical Trials			
<p align="center">Prior Authorization Requirement</p> <p>You must obtain prior authorization as soon as the possibility of participation in a clinical trial arises. If you fail to obtain prior authorization as required, you will be responsible for paying all charges and no Benefits will be paid.</p>			
Depending upon the Covered Health Service, Benefit limits are the same	<p><i>Network</i> Depending upon where the Covered Health Service is provided,</p>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
as those stated under the specific Benefit category in this <i>Schedule of Benefits</i> . Benefits are available when the Covered Health Services are provided by either Network or non-Network providers, however the non-Network provider must agree to accept the Network level of reimbursement by signing a network provider agreement specifically for the patient enrolling in the trial. (Non-Network Benefits are not available if the non-Network provider does not agree to accept the Network level of reimbursement.)	Benefits will be the same as those stated under each Covered Health Service category in this Schedule of Benefits. <i>Non-Network</i> Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
3. Diabetes Services			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment for the management and treatment of diabetes that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Diabetes Self-Management and Training/Diabetic Eye Examinations/Foot Care	<i>Network</i> Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . <i>Non-Network</i> Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management and training/diabetic eye examinations/foot care will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
Diabetes Self-Management Items	<i>Network</i> Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i> .		

<i>When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.</i>			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i> . <i>Non-Network</i> Depending upon where the Covered Health Service is provided, Benefits for diabetes self-management items will be the same as those stated under <i>Durable Medical Equipment</i> and in the <i>Outpatient Prescription Drug Rider</i> . Benefits for diabetes supplies will be the same as those stated in the <i>Outpatient Prescription Drug Rider</i> .		
4. Durable Medical Equipment			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization before obtaining any Durable Medical Equipment that exceeds \$1,000 in cost (either retail purchase cost or cumulative retail rental cost of a single item). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
To receive Network Benefits, you must purchase or rent the Durable Medical Equipment from the vendor we identify or purchase it directly from the prescribing Network Physician.	<i>Network</i> 70% <i>Non-Network</i> 50%	Yes Yes	Yes Yes
5. Emergency Health Services - Outpatient			
Note: If you are confined in a non-Network Hospital after you receive outpatient Emergency Health Services, you must notify us within one business day or on the same day of admission if reasonably possible. We may elect to transfer you to a Network Hospital as soon as it is medically appropriate to do so. If you choose to stay in the non-Network Hospital after the date we decide a transfer is medically appropriate, Network Benefits will not be provided. Non-Network Benefits may be	<i>Network</i> 70%	Yes	Yes, after the Per Occurrence Deductible of \$500 per visit is satisfied

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
available if the continued stay is determined to be a Covered Health Service. Eligible Expenses for Emergency Health Services provided by a non-Network provider will be determined as described below under <i>Eligible Expenses</i> in this <i>Schedule of Benefits</i> . As a result, you will be responsible for the difference between the amount billed by the non-Network provider and the amount we determine to be an Eligible Expense for reimbursement.	 <		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Services that are provided in lieu of an Inpatient Stay are not subject to this limit.	Non-Network 50%	Yes	Yes
8. Hospice Care			
<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before admission for an Inpatient Stay in a hospice facility or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-Network Benefits, you must contact us within 24 hours of admission for an Inpatient Stay in a hospice facility.</p>			
	Network 70% Non-Network 50%	Yes Yes	Yes Yes
9. Hospital - Inpatient Stay			
<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.</p>			
	Network 70% for services provided with a referral from your Primary Physician for services provided by a Network Physician 50% for services provided without a referral from your Primary Physician for services provided by a	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Network Physician Non-Network 50%	Yes	Yes
10. Lab, X-Ray and Diagnostics - Outpatient			
Prior Authorization Requirement For Non-Network Benefits for sleep studies, you must obtain prior authorization five business days before scheduled services are received. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Lab Testing - Outpatient:	Network 70% at a free-standing lab or in a Physician's office 50% at a Hospital-based lab Non-Network 50% at a free-standing lab or in a Physician's office 50% at a Hospital-based lab	Yes Yes	Yes Yes
X-Ray and Other Diagnostic Testing - Outpatient:	Network 70% at a free-standing diagnostic center or in a Physician's office 50% at an outpatient Hospital-based diagnostic center Non-Network 50% at a free-standing diagnostic center or in a Physician's office 50% at an outpatient	Yes Yes	Yes Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Hospital-based diagnostic center	Yes	Yes
11. Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA, BEAM, ECT and Nuclear Medicine - Outpatient			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	<p><i>Network</i></p> <p>70% at a free-standing diagnostic center or in a Physician's office</p> <p>70% at an outpatient Hospital-based diagnostic center</p> <p><i>Non-Network</i></p> <p>50% at a free-standing diagnostic center or in a Physician's office</p> <p>50% at an outpatient Hospital-based diagnostic center</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes, after the Per Occurrence Deductible of \$400 per service is satisfied</p> <p>Yes</p> <p>Yes, after the Per Occurrence Deductible of \$400 per service is satisfied</p>
12. Mental Health Services			
<p style="text-align: center;">Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission for Mental Health Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions.</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; outpatient</p>			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>electro-convulsive treatment; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	<p><i>Network</i></p> <p><i>Inpatient</i></p> <p>70%</p> <p><i>Outpatient</i></p> <p>100% after you pay a Copayment of \$30 per visit</p> <p>70% for Partial Hospitalization/Intensive Outpatient Treatment</p> <p><i>Non-Network</i></p> <p><i>Inpatient</i></p> <p>50%</p> <p><i>Outpatient</i></p> <p>50%</p> <p>50% for Partial Hospitalization/Intensive Outpatient Treatment</p>	<p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>No</p> <p>Yes</p> <p>Yes</p> <p>Yes</p> <p>Yes</p>
13. Neurodevelopmental Disorders - Autism Spectrum Disorder Services	<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission for Neurodevelopmental Disorders - Autism Spectrum Disorder Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions.</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management; Behavioral Therapy.</p>		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	<i>Network</i> <i>Inpatient</i> 70% <i>Outpatient</i> 100% after you pay a Copayment of \$30 per visit 70% for Partial Hospitalization/Intensive Outpatient Treatment <i>Non-Network</i> <i>Inpatient</i> 50% <i>Outpatient</i> 50% 50% for Partial Hospitalization/Intensive Outpatient Treatment	Yes Yes Yes Yes Yes Yes	Yes No Yes Yes Yes Yes
14. Pharmaceutical Products - Outpatient			
	<i>Network</i> 70% <i>Non-Network</i> 50%	Yes Yes	Yes Yes
15. Physician Fees for Surgical and Medical Services			
	<i>Network</i> 70% for services provided by your Primary Physician or by	Yes	Yes

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Covered Health Services provided by a non-Network facility based Physician in a Network facility will be paid at the Network Benefits level, however Eligible Expenses will be determined as described below under Eligible Expenses in this <i>Schedule of Benefits</i> . As a result, you will be responsible to the non-Network facility based Physician for any amount billed that is greater than the amount we determine to be an Eligible Expense. In order to obtain the highest level of Benefits, you should confirm the Network status of these providers prior to obtaining Covered Health Services.	a Network obstetrician or gynecologist 70% for services provided with a referral from your Primary Physician for services provided by a Network Physician 50% for services provided without a referral from your Primary Physician for services provided by a Network Physician <i>Non-Network</i> 50%	Yes	Yes
16. Physician's Office Services - Sickness and Injury			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization as soon as is reasonably possible before Genetic Testing - BRCA is performed. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
In addition to the office visit Copayment stated in this section, the Copayments/Coinsurance and any	Network 100% after you pay a	Yes	No

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
deductible for the following services apply when the Covered Health Service is performed in a Physician's office: <ul style="list-style-type: none">Lab, radiology/X-rays and other diagnostic services described under <i>Lab, X-Ray and Diagnostics - Outpatient</i>.Major diagnostic and nuclear medicine described under <i>Lab, X-Ray and Major Diagnostics - CT, PET, MRI, MRA, BEAM, ECT and Nuclear Medicine - Outpatient</i>.Outpatient Pharmaceutical Products described under <i>Pharmaceutical Products - Outpatient</i>.Diagnostic and therapeutic scopic procedures described under <i>Scopic Procedures - Outpatient Diagnostic and Therapeutic</i>.Outpatient surgery procedures described under <i>Surgery - Outpatient</i>.Outpatient therapeutic procedures described under <i>Therapeutic Treatments - Outpatient</i>.	Copayment of \$30 per visit for services provided by your Primary Physician or by a Network obstetrician or gynecologist 100% after you pay a Copayment of \$60 per visit for services provided with a referral from your Primary Physician for services provided by a Network Physician 100% after you pay a Copayment of \$100 per visit for services provided without a referral from your Primary Physician for services provided by a Network Physician <		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
reduced to 50% of Eligible Expenses.			
It is important that you notify us regarding your Pregnancy. Your notification will open the opportunity to become enrolled in prenatal programs that are designed to achieve the best outcomes for you and your baby.			
	<p><i>Network</i></p> <p>Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</p> <p><i>Non-Network</i></p> <p>Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> except that an Annual Deductible will not apply for a newborn child whose length of stay in the Hospital is the same as the mother's length of stay.</p>		
18. Preventive Care Services			
Physician office services	<p><i>Network</i></p> <p>100% for services provided by your Primary Physician or by a Network obstetrician or gynecologist</p> <p>100% for services provided with a referral from your Primary Physician for services provided by a Network Physician</p> <p>100% for services provided without a referral from your Primary Physician for services provided by a Network Physician</p> <p><i>Non-Network</i></p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>Yes</p>

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Lab, X-ray or other preventive tests	<p><i>Network</i></p> <p>100% for services provided by your Primary Physician or by a Network obstetrician or gynecologist</p> <p>100% for services provided with a referral from your Primary Physician for services provided by a Network Physician</p> <p>100% for services provided without a referral from your Primary Physician for services provided by a Network Physician</p> <p><i>Non-Network</i></p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>Yes</p>
Breast pumps	<p><i>Network</i></p> <p>100%</p> <p><i>Non-Network</i></p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>No</p> <p>Yes</p>
19. Prosthetic Devices	<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization before obtaining prosthetic devices that exceed \$1,000 in cost per device. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>		
	<p><i>Network</i></p> <p>70%</p> <p><i>Non-Network</i></p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
20. Reconstructive Procedures			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before a scheduled reconstructive procedure is performed or, for non-scheduled procedures, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions or as soon as is reasonably possible for non-scheduled inpatient admissions.</p>			
	<p><i>Network</i></p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>Non-Network</i></p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
21. Rehabilitation Services - Outpatient Therapy			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before receiving physical therapy, occupational therapy and speech therapy, or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
Limited to 60 visits per year for any combination of physical therapy, occupational therapy, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy and/or cognitive rehabilitation therapy.	<p><i>Network</i></p> <p>70%</p> <p><i>Non-Network</i></p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
22. Scopic Procedures - Outpatient Diagnostic and Therapeutic			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	<p><i>Network</i></p> <p>70% at a free-standing center or in a Physician's office for services provided by your Primary Physician or by a Network obstetrician or gynecologist</p> <p>70% at a free-standing center or in a Physician's office for services provided with a referral from your Primary Physician for services provided by a Network Physician</p> <p>50% at a free-standing center or in a Physician's office for services provided without a referral from your Primary Physician for services provided by a Network Physician</p>	Yes	Yes
	<p>70% at an outpatient Hospital-based center for services provided by your Primary Physician or by a Network obstetrician or gynecologist</p> <p>70% at an outpatient Hospital-based center for services provided with a referral from your</p>	Yes	Yes, after the Per Occurrence Deductible of \$400 per date of service is satisfied

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Primary Physician for services provided by a Network Physician 50% at an outpatient Hospital-based center for services provided without a referral from your Primary Physician for services provided by a Network Physician <i>Non-Network</i> 50% at a free-standing center or in a Physician's office 50% at an outpatient Hospital-based center	 Yes Yes	 Yes Yes, after the Per Occurrence Deductible of \$400 per date of service is satisfied
23. Skilled Nursing Facility/Inpatient Rehabilitation Facility Services			
<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits for a scheduled admission, you must obtain prior authorization five business days before admission, or as soon as is reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.</p>			
Limited to 90 days per year.	<i>Network</i> 70% <i>Non-Network</i> 50%	 Yes Yes	 Yes Yes
24. Substance-Related and Addictive Disorders Services			
<p align="center">Prior Authorization Requirement</p>			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>For Non-Network Benefits for a scheduled admission for Substance-Related and Addictive Disorders Services (including an admission for Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility) you must obtain authorization prior to the admission or as soon as is reasonably possible for non-scheduled admissions.</p> <p>In addition, for Non-Network Benefits you must obtain prior authorization before the following services are received. Services requiring prior authorization: Intensive Outpatient Treatment programs; psychological testing; extended outpatient treatment visits beyond 45 - 50 minutes in duration, with or without medication management.</p> <p>If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	<i>Network</i> <i>Inpatient</i> 70% <i>Outpatient</i> 100% after you pay a Copayment of \$30 per visit 70% for Partial Hospitalization/Intensive Outpatient Treatment	Yes Yes Yes	Yes No Yes
	<i>Non-Network</i> <i>Inpatient</i> 50% <i>Outpatient</i> 50% 50% for Partial Hospitalization/Intensive Outpatient Treatment	Yes Yes Yes	Yes Yes Yes
25. Surgery - Outpatient			
<p align="center">Prior Authorization Requirement</p> <p>For Non-Network Benefits for cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, diagnostic catheterization and electrophysiology implant and sleep apnea surgery you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain</p>			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	<p><i>Network</i></p> <p>70% at an ambulatory surgical center or in a Physician's office for services provided by your Primary Physician or by a Network obstetrician or gynecologist</p> <p>70% at an ambulatory surgical center or in a Physician's office for services provided with a referral from your Primary Physician for services provided by a Network Physician</p> <p>50% at an ambulatory surgical center or in a Physician's office for services provided without a referral from your Primary Physician for services provided by a Network Physician</p>	Yes	Yes
	<p>70% at an outpatient Hospital-based surgical center for services provided by your Primary Physician or by a Network obstetrician or gynecologist</p> <p>70% at an outpatient Hospital-based surgical center for services provided with a referral from your Primary Physician for services provided by a Network Physician</p>	Yes	Yes, after the Per Occurrence Deductible of \$400 per date of service is satisfied

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	50% at an outpatient Hospital-based surgical center for services provided without a referral from your Primary Physician for services provided by a Network Physician Non-Network 50% at an ambulatory surgical center or in a Physician's office 50% at an outpatient Hospital-based surgical center	Yes Yes	Yes Yes, after the Per Occurrence Deductible of \$400 per date of service is satisfied
26. Therapeutic Treatments - Outpatient			
Prior Authorization Requirement For Non-Network Benefits you must obtain prior authorization for the following outpatient therapeutic services five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. Services that require prior authorization: dialysis, intensity modulated radiation therapy and MR-guided focused ultrasound. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network 70% Non-Network 50%	Yes Yes	Yes Yes
27. Transplantation Services			
Prior Authorization Requirement For Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you don't obtain prior authorization and if, as a result, the services are not performed at a Designated Facility, Network Benefits will not be paid.			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>For Non-Network Benefits you must obtain prior authorization as soon as the possibility of a transplant arises (and before the time a pre-transplantation evaluation is performed at a transplant center). If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled admissions or as soon as is reasonably possible for non-scheduled admissions.</p>			
For Network Benefits, transplantation services must be received at a Designated Facility. We do not require that cornea transplants be performed at a Designated Facility in order for you to receive Network Benefits.	<p><i>Network</i></p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p> <p><i>Non-Network</i></p> <p>Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i>.</p>		
28. Urgent Care Center Services			
	<p><i>Network</i></p> <p>70%</p> <p><i>Non-Network</i></p> <p>50%</p>	<p>Yes</p> <p>Yes</p>	<p>Yes</p> <p>Yes</p>
29. Virtual Visits			
Network Benefits are available only when services are delivered through a Designated Virtual Network Provider. You can find a Designated Virtual Network Provider by going to www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.	<p><i>Network</i></p> <p>100% after you pay a Copayment of \$10 per visit</p>	Yes	No
	<p><i>Non-Network</i></p> <p>50%</p>	Yes	Yes
Additional Benefits Required By Arizona Law			
30. Dental Services - Accident Only			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
Prior Authorization Requirement For Non-Network Benefits, you must obtain prior authorization five business days before follow-up (post-Emergency) treatment begins. You do not have to obtain prior authorization before the initial Emergency treatment. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network 70% Non-Network 50%	Yes Yes	Yes Yes
31. Dental Services - Hospital or Alternative Facility/Anesthesia			
Prior Authorization Requirement For Non-Network Benefits, you must obtain prior authorization five business days before admission or as soon as reasonably possible for non-scheduled admissions. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
	Network 70% Non-Network 50%	Yes Yes	Yes Yes
32. Hearing Aids			
Prior Authorization Requirement For Non-Network Benefits, you must obtain prior authorization before obtaining a hearing aid that exceeds \$1,000 in retail purchase cost. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.			
Benefits are limited to one hearing aid per ear every calendar year. Benefits also include repair and replacement.	Network 70% Non-Network 50%	Yes Yes	Yes Yes
33. Manipulative Treatment			

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits, you must obtain prior authorization five business days before receiving Manipulative Treatment or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	Network 70%	Yes	Yes
	Non-Network 50%	Yes	Yes
34. Obesity Surgery			
<p>Prior Authorization Requirement</p> <p>You must obtain prior authorization six months prior to surgery or as soon as the possibility of obesity surgery arises. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p> <p>In addition, for non-Network Benefits you must contact us 24 hours before admission for an Inpatient stay.</p> <p>It is important that you notify us regarding your intention to have surgery. Your notification will open the opportunity to become enrolled in programs designed to achieve the best outcomes for you.</p>			
	Network (Designated Facility) 70%	Yes	Yes
	Network (Non-Designated Facility) 50%	Yes	Yes
	Non-Network 50%	Yes	Yes
35. Orthognathic Surgery			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits, you must obtain prior authorization five business days before scheduled services are received or, for non-scheduled services, within one business day or as soon as is reasonably possible. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
	Network		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
36. Ostomy Supplies			
	Network 70% Non-Network 50%	Yes Yes	Yes Yes
37. Telemedicine Services			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Non-Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
38. Temporomandibular Joint (TMJ) Services			
Prior Authorization Requirement For Non-Network Benefits, you must obtain prior authorization five business days before temporomandibular joint services are performed during an Inpatient Stay in a Hospital. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses. In addition, for Non-Network Benefits you must contact us 24 hours before admission for scheduled inpatient admissions.			
	Network Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> . Non-Network		

When Benefit limits apply, the limit refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.			
Covered Health Service	Benefit (The Amount We Pay, based on Eligible Expenses)	Deductibles, Copayments and Coinsurance apply to the Out-of-Pocket Maximum?	Must You Meet Annual Deductible?
	Depending upon where the Covered Health Service is provided, Benefits will be the same as those stated under each Covered Health Service category in this <i>Schedule of Benefits</i> .		
39. Vision Correction after Surgery			
<p>Prior Authorization Requirement</p> <p>For Non-Network Benefits, you must obtain prior authorization before obtaining vision correction after surgery services. If you fail to obtain prior authorization as required, Benefits will be reduced to 50% of Eligible Expenses.</p>			
Benefits will be limited to the first pair of contacts for treatment of keratoconus or post-cataract surgery.	Network	Yes	Yes
	Non-Network	Yes	Yes

Eligible Expenses

Eligible Expenses are the amount we determine that we will pay for Benefits. For Network Benefits for Covered Health Services provided by a Network provider, you are not responsible for any difference between Eligible Expenses and the amount the provider bills. For Covered Health Services provided by a non-Network provider (other than services otherwise arranged by us), you will be responsible to the non-Network provider for any amount billed that is greater than the amount we determine to be an Eligible Expense as described below. For Non-Network Benefits, you are responsible for paying, directly to the non-Network provider, any difference between the amount the provider bills you and the amount we will pay for Eligible Expenses, except as specifically set forth in this *Schedule of Benefits*. Eligible Expenses are determined solely in accordance with our reimbursement policy guidelines, as described in the *Policy*.

For Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a Network provider, Eligible Expenses are our contracted fee(s) with that provider.
- When Covered Health Services are received from a non-Network provider as arranged by us, Eligible Expenses are billed charges unless a lower amount is negotiated or authorized by law.

For Non-Network Benefits, Eligible Expenses are based on the following:

- When Covered Health Services are received from a non-Network provider, Eligible Expenses are determined, based on:
 - Negotiated rates agreed to by the non-Network provider and either us or one of our vendors, affiliates or subcontractors, as we determine.
 - If rates have not been negotiated, then one of the following amounts:

- ♦ Eligible Expenses are determined based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for Medicare for the same or similar service within the geographic market with the exception of the following:
 - 50% of *CMS* for the same or similar laboratory service.
 - 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.
- ♦ When a rate is not published by *CMS* for the service, we use an available gap methodology to determine a rate for the service as follows:
 - For services other than Pharmaceutical Products, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale(s) currently in use become no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.
 - For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems*, *Thomson Reuters* (published in its Red Book), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.
- ♦ When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.
- ♦ For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

We update the *CMS* published rate data on a regular basis when updated data from *CMS* becomes available. These updates are typically implemented within 30 to 90 days after *CMS* updates its data.

For Covered Health Services received at a Network facility on a non-Emergency basis from a non-Network facility based Physician, the Eligible Expense is based on 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market with the exception of the following:

- 50% of *CMS* for the same or similar laboratory service.
- 45% of *CMS* for the same or similar durable medical equipment, or *CMS* competitive bid rates.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the

pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

For Mental Health Services and Substance-Related and Addictive Disorders Services the Eligible Expense will be reduced by 25% for Covered Health Services provided by a psychologist and by 35% for Covered Health Services provided by a masters level counselor.

IMPORTANT NOTICE: Non-Network facility based Physicians may bill you for any difference between the Physician's billed charges and the Eligible Expense described here.

For Emergency Health Services provided by a non-Network provider, the Eligible Expense is a rate agreed upon by the non-Network provider or determined based upon the higher of:

- The median amount negotiated with Network providers for the same service.
- 110% of the published rates allowed by the *Centers for Medicare and Medicaid Services (CMS)* for the same or similar service within the geographic market.

When a rate is not published by *CMS* for the service, we use a gap methodology established by *OptumInsight* and/or a third party vendor that uses a relative value scale. The relative value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative value scale currently in use becomes no longer available, we will use a comparable scale(s). We and *OptumInsight* are related companies through common ownership by *UnitedHealth Group*. Refer to our website at www.myuhc.com for information regarding the vendor that provides the applicable gap fill relative value scale information.

For Pharmaceutical Products, we use gap methodologies that are similar to the pricing methodology used by *CMS*, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by *RJ Health Systems, Thomson Reuters* (published in its *Red Book*), or *UnitedHealthcare* based on an internally developed pharmaceutical pricing resource.

When a rate is not published by *CMS* for the service and a gap methodology does not apply to the service, the Eligible Expense is based on 50% of the provider's billed charge.

IMPORTANT NOTICE: Non-Network providers may bill you for any difference between the provider's billed charges and the Eligible Expense described here.

Provider Network

We arrange for health care providers to participate in a Network. Network providers are independent practitioners. They are not our employees. It is your responsibility to select your provider.

Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.

Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card to request a copy.

It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Network Benefits.

If you are currently undergoing a course of treatment utilizing a non-Network Physician or health care facility, you may be eligible to receive transition of care Benefits. This transition period is available for specific medical services and for limited periods of time. If you have questions regarding this transition of

care reimbursement policy or would like help determining whether you are eligible for transition of care Benefits, please contact *Customer Care* at the telephone number on your ID card.

Do not assume that a Network provider's agreement includes all Covered Health Services. Some Network providers contract with us to provide only certain Covered Health Services, but not all Covered Health Services. Some Network providers choose to be a Network provider for only some of our products. Refer to your provider directory or contact us for assistance.

Continuity of Care

A new Covered Person whose current health care provider is not a Network provider may request, in writing, to continue an active course of treatment with that non-Network provider during a transitional period after the effective date of enrollment. Both of the following provisions related to the Covered Person and the Covered Person's health care provider must apply.

- The Covered Person has either:
 - ♦ A life-threatening disease or condition, in which case the transitional period is not more than 30 days after the effective date of the enrollment; or
 - ♦ Entered the third trimester of Pregnancy on the effective date of the enrollment, in which case the transitional period include the delivery and care related to the delivery up to six weeks after the delivery.
- The Covered Person's health care provider agrees in writing to do all of the following:
 - ♦ Accept as payment in full our Network rates that apply to similar services provided by Network providers (except for applicable Copayment or Annual Deductible amounts).
 - ♦ Comply with our quality assurance requirements and provide us with any necessary medical information related to the care.
 - ♦ Comply with our policies and procedures including procedures relating to referrals, prior notification and claims handling.

Any Covered Person whose health care provider is terminated by us from the provider Network (except for reasons of medical incompetence or unprofessional conduct) may request, in writing, to continue an active course of treatment with that health care provider during a transitional period after the date the provider is no longer in the Network. Both of the following provisions related to the Covered Person and the Covered Person's health care provider must apply.

- The Covered Person has either:
 - ♦ A life-threatening disease or condition, in which case the transitional period is not more than 30 days after the date the provider is no longer in the Network; or
 - ♦ Entered the third trimester of Pregnancy on the date the provider is no longer in the Network, in which case the transitional period includes the delivery and any care related to the delivery up to six weeks after the delivery.
- The Covered Person's health care provider agrees in writing to do all of the following:
 - ♦ Continue to accept as payment in full our Network rates that were applicable before the beginning of the transitional period (except for applicable Copayment or Annual Deductible amounts).
 - ♦ Comply with our quality assurance requirements and provide us with any necessary medical information related to the care.
 - ♦ Comply with our policies and procedures including procedures relating to referrals, prior notification and claims handling.

Additional Network Availability

Certain Covered Health Services defined below may also be provided through the W500 Network. Go to www.myuhc.com or contact *Customer Care* for the W500 provider directory. You are eligible for Network Benefits when these certain Covered Health Services are received from providers who are contracted with us through the W500 Network.

These Covered Health Services are limited to the services listed below, as described in *Section 1: Covered Health Services*:

- *Emergency Health Services – Outpatient.*
- *Hospital – Inpatient Stay*, when you are admitted to the Hospital on an unscheduled basis because of an Emergency. Benefits for services provided while you are confined in a Hospital also include Covered Health Services as described under *Physician Fees for Surgical and Medical Services*.
- Urgent care services provided as described under *Urgent Care Center Services*. Urgent care services are those Covered Health Services that are required to prevent serious deterioration of your health, and that are required as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

Also, if we determine that specific Covered Health Services are not available from a Compass Plus Network provider, you may be eligible for Network Benefits when Covered Health Services are received from a W500 Network provider. In this situation, before you receive these Covered Health Services, your Compass Plus Network Physician will notify us and, if we confirm that the Covered Health Services are not available from a Compass Plus Network provider, we will work with you and your Compass Plus Network Physician to coordinate these Covered Health Services through a W500 Network provider.

Second Medical Opinion

A second medical opinion is a reevaluation of your condition or health care treatment by an appropriately qualified Physician or appropriately qualified health care professional. In most cases, you or your treating Physician or health care professional will request a second medical opinion without consulting us. A second medical opinion is covered under the *Physician's Office Services - Sickness and Injury* Benefit.

Please Note: The fact that an appropriately qualified Physician or health care professional gives a second medical opinion and recommends a particular treatment, diagnostic test or service does not necessarily mean that the recommended health care service is Medically Necessary or a Covered Health Service under the Policy. The health care service, supply or Pharmaceutical Product is only a Covered Health Service if it is Medically Necessary and a Covered Health Service under the Policy. Please see *Section 1: Covered Health Services* in the Policy for the Benefits available under the Policy.

Designated Facilities and Other Providers

If you have a medical condition that we believe needs special services, we may direct you to a Designated Facility or Designated Physician chosen by us. If you require certain complex Covered Health Services for which expertise is limited, we may direct you to a Network facility or provider that is outside your local geographic area. If you are required to travel to obtain such Covered Health Services from a Designated Facility or Designated Physician, we may reimburse certain travel expenses as we determine.

In both cases, Network Benefits will only be paid if your Covered Health Services for that condition are provided by or arranged by the Designated Facility, Designated Physician or other provider chosen by us.

You or your Primary Physician or other Network Physician must notify us of special service needs (such as transplants or cancer treatment) that might warrant referral to a Designated Facility or Designated Physician. If you do not notify us in advance, and if you receive services from a non-Network facility (regardless of whether it is a Designated Facility) or other non-Network provider, Network Benefits will not be paid. Non-Network Benefits may be available if the special needs services you receive are Covered Health Services for which Benefits are provided under the Policy.

Health Services from Non-Network Providers Paid as Network Benefits

If specific Covered Health Services are not available from a Network provider, you may be eligible for Network Benefits when Covered Health Services are received from non-Network providers. In this situation, your Primary Physician will notify us and, if we confirm that care is not available from a Network provider, we will work with you and your Primary Physician to coordinate care through a non-Network provider.

All Savers Insurance Company

Outpatient Prescription Drug

Schedule of Benefits

Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception.

Benefits for Oral Chemotherapeutic Agents

Oral chemotherapeutic agent Prescription Drug Products will be provided at a level no less favorable than chemotherapeutic agents are provided under *Pharmaceutical Products – Outpatient* in your Certificate of Coverage, regardless of tier placement.

If a Brand-name Drug Becomes Available as a Generic

If a Generic becomes available for a Brand-name Prescription Drug Product, the tier placement of the Brand-name Prescription Drug Product may change, and therefore your Copayment and/or Coinsurance may change and an Ancillary Charge may apply, or you will no longer have Benefits for that particular Brand-name Prescription Drug Product.

Supply Limits

Benefits for Prescription Drug Products are subject to the supply limits that are stated in the "Description and Supply Limits" column of the Benefit Information table. For a single Copayment and/or Coinsurance, you may receive a Prescription Drug Product up to the stated supply limit.

Note: Some products are subject to additional supply limits based on criteria that we have developed, subject to our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply, or may require that a minimum amount be dispensed.

You may determine whether a Prescription Drug Product has been assigned a supply limit for dispensing through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prior Authorization Requirements

Before certain Prescription Drug Products are dispensed to you, either your Physician, your pharmacist or you are required to obtain prior authorization from us or our designee. The reason for obtaining prior authorization from us is to determine whether the Prescription Drug Product, in accordance with our approved guidelines, is each of the following:

- It meets the definition of a Covered Health Service.
- It is not an Experimental or Investigational or Unproven Service.

We may also require you to obtain prior authorization from us or our designee so we can determine whether the Prescription Drug Product, in accordance with our approved guidelines, was prescribed by a Specialist Physician.

Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a Network Pharmacy, the prescribing provider, the pharmacist, or you are responsible for obtaining prior authorization from us.

Non-Network Pharmacy Prior Authorization

When Prescription Drug Products are dispensed at a non-Network Pharmacy, you or your Physician are responsible for obtaining prior authorization from us as required.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you may pay more for that Prescription Order or Refill. The Prescription Drug Products requiring prior authorization are subject to our periodic review and modification. You may determine whether a particular Prescription Drug Product requires prior authorization through the Internet at www.myuhc.com or by calling Customer Care at the telephone number on your ID card.

If you do not obtain prior authorization from us before the Prescription Drug Product is dispensed, you can ask us to consider reimbursement after you receive the Prescription Drug Product. You will be required to pay for the Prescription Drug Product at the pharmacy. Our contracted pharmacy reimbursement rates (our Prescription Drug Charge) will not be available to you at a non-Network Pharmacy. You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*.

When you submit a claim on this basis, you may pay more because you did not obtain prior authorization from us before the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge (for Prescription Drug Products from a Network Pharmacy) or the Predominant Reimbursement Rate (for Prescription Drug Products from a non-Network Pharmacy), less the required Copayment and/or Coinsurance, Ancillary Charge and any deductible that applies.

Benefits may not be available for the Prescription Drug Product after we review the documentation provided and we determine that the Prescription Drug Product is not a Covered Health Service or it is an Experimental or Investigational or Unproven Service.

We may also require prior authorization for certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on available programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Step Therapy

Certain Prescription Drug Products for which Benefits are described under this Prescription Drug Rider or Pharmaceutical Products for which Benefits are described in your Policy are subject to step therapy requirements. This means that in order to receive Benefits for such Prescription Drug Products and/or Pharmaceutical Products you are required to use a different Prescription Drug Product(s) or Pharmaceutical Product(s) first.

You may determine whether a particular Prescription Drug Product or Pharmaceutical Product is subject to step therapy requirements through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

What You Must Pay

You are responsible for paying the applicable Copayment and/or Coinsurance described in the Benefit Information table, in addition to any Ancillary Charge. You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.

An Ancillary Charge may apply when a covered Prescription Drug Product is dispensed at your or the provider's request and there is another drug that is chemically the same available at a lower tier. When you choose the higher tiered drug of the two, you will pay the difference between the higher tiered drug

and the lower tiered drug in addition to your Copayment and/or Coinsurance that applies to the higher tier drug.

The amount you pay for any of the following under this Rider will not be included in calculating any Out-of-Pocket Maximum stated in your Policy:

- The difference between the Predominant Reimbursement Rate and a non-Network Pharmacy's Usual and Customary Charge for a Prescription Drug Product.
- Any non-covered drug product. You are responsible for paying 100% of the cost (the amount the pharmacy charges you) for any non-covered drug product and our contracted rates (our Prescription Drug Charge) will not be available to you.

Your Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Urgent Requests

If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours.

External Review

If you are not satisfied with our determination of your exclusion exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your ID card. The *Independent Review Organization (IRO)* will notify you of our determination within 72 hours.

Expedited External Review

If you are not satisfied with our determination of your exclusion exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. The *IRO* will notify you of our determination within 24 hours.

Payment Information

Payment Term And Description	Amounts
Copayment and Coinsurance	
<p><i>Copayment</i></p> <p>Copayment for a Prescription Drug Product at a Network or non-Network Pharmacy is a specific dollar amount.</p> <p><i>Coinsurance</i></p> <p>Coinsurance for a Prescription Drug Product at a Network Pharmacy is a percentage of the Prescription Drug Charge.</p> <p>Coinsurance for a Prescription Drug Product at a non-Network Pharmacy is a percentage of the Predominant Reimbursement Rate.</p> <p><i>Copayment and Coinsurance</i></p> <p>Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned a Prescription Drug Product.</p> <p>Your Copayment and/or Coinsurance may be reduced when you participate in certain programs which may have specific requirements for participation and/or activation of an enhanced level of Benefits associated with such programs. You may access information on these programs and any applicable prior authorization, participation or activation requirements associated with such programs through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Special Programs: We may have certain programs in which you may receive a reduced or increased Copayment and/or Coinsurance based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. If a program provides incentives for meeting certain criteria, we will provide a</p>	<p>For Prescription Drug Products at a retail Network Pharmacy, you are responsible for paying the lower of:</p> <ul style="list-style-type: none"> • The applicable Copayment and/or Coinsurance. • The Network Pharmacy's Usual and Customary Charge for the Prescription Drug Product. <p>See the Copayments and/or Coinsurance stated in the Benefit Information table for amounts.</p> <p>You are not responsible for paying a Copayment and/or Coinsurance for Preventive Care Medications.</p>

Payment Term And Description	Amounts
<p>reasonable alternative standard to qualify for the incentive to any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet a specified target. You may access information on these programs through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>Copayment/Coinsurance Waiver Program: If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.</p> <p>Prescription Drug Products Prescribed by a Specialist Physician: You may receive a reduced or increased Copayment and/or Coinsurance based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to a reduced or increased Copayment and/or Coinsurance through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.</p> <p>NOTE: The tier status of a Prescription Drug Product can change periodically, generally quarterly but no more than six times per calendar year, based on the Prescription Drug List (PDL) Management Committee's periodic tiering decisions. When that occurs, you may pay more or less for a Prescription Drug Product, depending on its tier assignment. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card for the most up-to-date tier status.</p> <p>Coupons: We may not permit you to use certain coupons or offers from pharmaceutical manufacturers to reduce your Copayment and/or Coinsurance.</p>	

Payment Term And Description	Amounts
You may access information on which coupons or offers are not permitted through the Internet at www.myuhc.com or by calling <i>Customer Care</i> at the telephone number on your ID card.	

Benefit Information

Description and Supply Limits	Benefit (The Amount We Pay)
Eosinophilic Gastrointestinal Disorder Formula	75% of the Prescription Drug Charge per Prescription Order or Refill for Eosinophilic Gastrointestinal Disorder Formula.
Medical Foods	50% of the Prescription Drug Charge per Prescription Order or Refill for Medical Foods to treat an Inherited Metabolic Disorder.
Prescription Drugs from a Retail Network Pharmacy The following supply limits apply: <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle supplied. When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3, or Tier 4. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug Charge per Prescription Order or Refill. However, you will not pay less than \$80 per Prescription Order or Refill. For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge per Prescription Order or Refill. However, you will not pay less than \$250 per Prescription Order or Refill. Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.
Prescription Drugs from a Retail Non-Network Pharmacy	
The following supply limits apply: <ul style="list-style-type: none"> As written by the provider, up to a consecutive 31-day supply of a Prescription Drug Product, unless adjusted based on the drug manufacturer's packaging size, or based on supply limits. A one-cycle supply of a contraceptive. You may obtain up to three cycles at one time if you pay a Copayment and/or Coinsurance for each cycle 	Your Copayment and/or Coinsurance is determined by the tier to which the Prescription Drug List (PDL) Management Committee has assigned the Prescription Drug Product. All Prescription Drug Products on the Prescription Drug List are assigned to Tier 1, Tier 2, Tier 3, or Tier 4. Please access www.myuhc.com through the Internet or call <i>Customer Care</i> at the telephone number on your ID card to determine tier status. For a Tier 1 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$5 per Prescription Order or Refill. For a Tier 2 Prescription Drug Product: 100% of the Prescription Drug Charge after you pay a Copayment of \$40 per Prescription Order or Refill. For a Tier 3 Prescription Drug Product: 80% of the Prescription Drug

Description and Supply Limits	Benefit (The Amount We Pay)
<p>supplied.</p> <p>When a Prescription Drug Product is packaged or designed to deliver in a manner that provides more than a consecutive 31-day supply, the Copayment and/or Coinsurance that applies will reflect the number of days dispensed.</p>	<p>Charge per Prescription Order or Refill. However, you will not pay less than \$80 per Prescription Order or Refill.</p> <p>For a Tier 4 Prescription Drug Product: 70% of the Prescription Drug Charge per Prescription Order or Refill. However, you will not pay less than \$250 per Prescription Order or Refill.</p> <p>Prescription Drug Products that are not on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List are not covered.</p>

Outpatient Prescription Drug Rider

All Savers Insurance Company

This Rider to the Policy provides Benefits for Prescription Drug Products.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Policy in *Section 8: Defined Terms* or in this Rider in *Section 3: Defined Terms*.

When we use the words "we," "us," and "our" in this document, we are referring to All Savers Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the Policy in *Section 8: Defined Terms*.

Patrick F. Carr



Introduction

Coverage Policies and Guidelines

Our Prescription Drug List (PDL) Management Committee is authorized to make tier placement changes on our behalf. The PDL Management Committee makes the final classification of an FDA-approved Prescription Drug Product to a certain tier by considering a number of factors including, but not limited to, clinical and economic factors. Clinical factors may include, but are not limited to, evaluations of the place in therapy, relative safety or relative efficacy of the Prescription Drug Product, as well as whether certain supply limits or prior authorization requirements should apply. Economic factors may include, but are not limited to, the Prescription Drug Product's acquisition cost including, but not limited to, available rebates and assessments on the cost effectiveness of the Prescription Drug Product.

Some Prescription Drug Products are more cost effective for specific indications as compared to others; therefore, a Prescription Drug Product may be listed on multiple tiers according to the indication for which the Prescription Drug Product was prescribed, or according to whether it was prescribed by a Specialist Physician.

We may periodically change the placement of a Prescription Drug Product among the tiers. These changes generally will occur quarterly, but no more than six times per calendar year. These changes may occur without prior notice to you.

When considering a Prescription Drug Product for tier placement, the PDL Management Committee reviews clinical and economic factors regarding Covered Persons as a general population. Whether a particular Prescription Drug Product is appropriate for an individual Covered Person is a determination that is made by the Covered Person and the prescribing Physician.

NOTE: The tier status of a Prescription Drug Product may change periodically based on the process described above. As a result of such changes, you may be required to pay more or less for that Prescription Drug Product. Please access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for the most up-to-date tier status.

Identification Card (ID Card) - Network Pharmacy

You must either show your ID card at the time you obtain your Prescription Drug Product at a Network Pharmacy or you must provide the Network Pharmacy with identifying information that can be verified by us during regular business hours.

If you don't show your ID card or provide verifiable information at a Network Pharmacy, you will be required to pay the Usual and Customary Charge for the Prescription Drug Product at the pharmacy.

You may seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim*. When you submit a claim on this basis, you may pay more because you failed to verify your eligibility when the Prescription Drug Product was dispensed. The amount you are reimbursed will be based on the Prescription Drug Charge, less the required Copayment and/or Coinsurance, Ancillary Charge, and any deductible that applies.

Submit your claim to:

Optum Rx
PO Box 29077
Hot Spring, AR 71903

Designated Pharmacies

If you require certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Prescription Drug Product.

Limitation on Selection of Pharmacies

If we determine that you may be using Prescription Drug Products in a harmful or abusive manner, or with harmful frequency, your selection of Network Pharmacies may be limited. If this happens, we may require you to select a single Network Pharmacy that will provide and coordinate all future pharmacy services. Benefits will be paid only if you use the designated single Network Pharmacy. If you don't make a selection within 31 days of the date we notify you, we will select a single Network Pharmacy for you.

Rebates and Other Payments

We may receive rebates for certain drugs included on the Prescription Drug List, including those drugs that you purchase prior to meeting the Annual Drug Deductible. We do not pass these rebates on to you, nor are they applied to the Annual Drug Deductible or Annual Deductible, or any combined medical and pharmacy Annual Deductible stated in the *Schedule of Benefits* attached to your Policy or taken into account in determining your Copayments and/or Coinsurance.

We, and a number of our affiliated entities, conduct business with various pharmaceutical manufacturers separate and apart from this *Outpatient Prescription Drug Rider*. Such business may include, but is not limited to, data collection, consulting, educational grants and research. Amounts received from pharmaceutical manufacturers pursuant to such arrangements are not related to this *Outpatient Prescription Drug Rider*. We are not required to pass on to you, and do not pass on to you, such amounts.

Coupons, Incentives and Other Communications

At various times, we may send mailings or provide other communications to you, your Physician, or your pharmacy that communicate a variety of messages, including information about Prescription and non-prescription Drug Products. These communications may include offers that enable you, at your discretion, to purchase the described product at a discount. Pharmaceutical manufacturers or other non-UnitedHealthcare entities may pay for and/or provide content for these communications and offers. Only you and your Physician can determine whether a change in your Prescription and/or non-prescription Drug regimen is appropriate for your medical condition.

Special Programs

We may have certain programs in which you may receive an enhanced or reduced Benefit based on your actions such as adherence/compliance to medication or treatment regimens, and/or participation in health management programs. If a program provides incentives for meeting certain criteria, we will provide a reasonable alternative standard to qualify for the incentive to any individual for whom it is unreasonably difficult due to a medical condition or medically inadvisable to meet a specified target. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Copayment/Coinsurance Waiver Program

If you are taking certain Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products, and you move to certain lower tier Prescription Drug Products or Specialty Prescription Drug Products, we may waive your Copayment and/or Coinsurance for one or more Prescription Orders or Refills.

Incentive Programs for Combined Medical and Pharmacy Annual Deductible Plans

When you are required to meet a combined medical and pharmacy Annual Deductible before we begin to pay Benefits, as stated in the *Schedule of Benefits* attached to your Policy, we may have certain programs in which you may receive an incentive based on your actions such as selecting a Tier 1 or Tier 2 Prescription Drug Product before you have satisfied your combined Annual Deductible. You may access information on these programs through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug Products Prescribed by a Specialist Physician

You may receive an enhanced or reduced Benefit, or no Benefit, based on whether the Prescription Drug Product was prescribed by a Specialist Physician. You may access information on which Prescription Drug Products are subject to Benefit enhancement, reduction or no Benefit through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Outpatient Prescription Drug Rider Table of Contents

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Section 1: Benefits for Prescription Drug Products

Benefits are available for Prescription Drug Products at either a Network Pharmacy or a non-Network Pharmacy and are subject to Copayments and/or Coinsurance or other payments that vary depending on which of the tiers of the Prescription Drug List the Prescription Drug Product is listed. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for applicable Copayments and/or Coinsurance requirements.

Benefits for Prescription Drug Products are available when the Prescription Drug Product meets the definition of a Covered Health Service or is prescribed to prevent conception. Benefits are also available for Preventive Care Medications as defined in *Section 3: Defined Terms* and include, but are not limited to:

- FDA-approved smoking cessation aids and/or drug products both prescribed and over-the-counter. The Covered Person must have a Prescription Order in order to receive Benefits.
- Over-the-counter aspirin in accordance with the current recommendations of the *United States Preventive Services Task Force* and prescribed by a provider.
- Over-the-counter insulin prescribed by a provider.

Benefits are available for refills of Prescription Drug Products only when dispensed as ordered by a duly licensed health care provider and only after 3/4 of the original Prescription Drug Product has been used.

Specialty Prescription Drug Products

Benefits are provided for Specialty Prescription Drug Products.

If you require Specialty Prescription Drug Products, we may direct you to a Designated Pharmacy with whom we have an arrangement to provide those Specialty Prescription Drug Products.

If you are directed to a Designated Pharmacy and you choose not to obtain your Specialty Prescription Drug Product from a Designated Pharmacy, you will be subject to the non-Network Benefit for that Specialty Prescription Drug Product.

Please see *Section 3: Defined Terms* for a full description of Specialty Prescription Drug Product and Designated Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on Specialty Prescription Drug Product supply limits.

Prescription Drugs from a Retail Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail Network Pharmacy supply limits.

Prescription Drugs from a Retail Non-Network Pharmacy

Benefits are provided for Prescription Drug Products dispensed by a retail non-Network Pharmacy.

If the Prescription Drug Product is dispensed by a retail non-Network Pharmacy, you must pay for the Prescription Drug Product at the time it is dispensed and then file a claim for reimbursement with us, as described in your Policy in *Section 5: How to File a Claim*. We will not reimburse you for the difference between the Predominant Reimbursement Rate and the non-Network Pharmacy's Usual and Customary Charge for that Prescription Drug Product. We will not reimburse you for any non-covered drug product.

In most cases, you will pay more if you obtain Prescription Drug Products from a non-Network Pharmacy.

Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details on retail non-Network Pharmacy supply limits.

Section 2: Exclusions

Exclusions from coverage listed in the Policy apply also to this Rider. In addition, the exclusions listed below apply.

When an exclusion applies to only certain Prescription Drug Products, you can access www.myuhc.com through the Internet or call *Customer Care* at the telephone number on your ID card for information on which Prescription Drug Products are excluded.

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.
2. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which is less than the minimum supply limit.
3. Prescription Drug Products dispensed outside the United States, except as required for Emergency treatment.
4. Drugs which are prescribed, dispensed or intended for use during an Inpatient Stay.
5. Experimental or Investigational or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by us to be experimental, investigational or unproven. This exclusion will not apply to drugs prescribed for the treatment of cancer if the drug has been recognized by the *Food and Drug Administration* as safe and effective for treatment of that specific type of cancer in one or more of the following acceptable standard medical reference compendia, or in medical literature listed below:
 - The acceptable standard medical reference compendia are the following:
 - ♦ *The American Hospital Formulary Service Drug Information*, a publication of the *American Society of Health System Pharmacists*.
 - ♦ *The National Comprehensive Cancer Network Drugs and Biologics Compendium*.
 - ♦ *Thomson Micromedex Compendium DRUGDEX*.
 - ♦ *Elsevier Gold Standard's Clinical Pharmacology Compendium*.
 - ♦ Other authoritative compendia as identified by the Secretary of the *United States Department of Health and Human Services*.
 - Medical literature may be accepted if all of the following apply:
 - ♦ At least two articles from major peer-reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.
 - ♦ No article from a major peer-reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.
 - ♦ The literature meets the uniform requirements for manuscripts submitted to biomedical journals established by the *International Committee of Medical Journal Editors*, or is published in a journal specified by the *United States Department of Health and Human Services* as acceptable peer-reviewed medical literature, pursuant to Section 186(t)(2)(B) of the Social Security Act (42 United States Code section 1395x(t)(2)(B)).
6. Prescription Drug Products furnished by the local, state or federal government. Any Prescription Drug Product to the extent payment or benefits are provided or available from the local, state or

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federal government (for example, Medicare) whether or not payment or benefits are received, except as otherwise provided by law.

7. Prescription Drug Products for any condition, Injury, Sickness or Mental Illness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
8. Any product dispensed for the purpose of appetite suppression or weight loss.
9. A Pharmaceutical Product for which Benefits are provided in your Policy. This exclusion does not apply to Depo Provera and other injectable drugs used for contraception.
10. Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically stated as covered.
11. General vitamins, except the following which require a Prescription Order or Refill: prenatal vitamins, vitamins with fluoride, and single entity vitamins.
12. Unit dose packaging or repackagers of Prescription Drug Products.
13. Medications used for cosmetic purposes.
14. Prescription Drug Products, including New Prescription Drug Products or new dosage forms, that we determine do not meet the definition of a Covered Health Service.
15. Prescription Drug Products as a replacement for a previously dispensed Prescription Drug Product that was lost, stolen, broken or destroyed.
16. Prescription Drug Products when prescribed to treat infertility.
17. Prescription Drug Products not included on Tier 1, Tier 2, Tier 3 or Tier 4 of the Prescription Drug List at the time the Prescription Order or Refill is dispensed. We have developed a process for evaluating Benefits for a Prescription Drug Product that is not on an available tier of the Prescription Drug List, but that has been prescribed as a Medically Necessary and appropriate alternative. For information about this process, contact Customer Care at the telephone number on your ID card.
18. Any prescription medication that must be compounded into its final form by the dispensing pharmacist, Physician, or other health care provider.
19. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless we have designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that we have determined are Therapeutically Equivalent to an over-the-counter drug or supplement. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. This exclusion does not apply to over-the-counter aids and/or drugs used for smoking cessation, aspirin or insulin for which Benefits are available as described in *Section 1: Benefits for Prescription Drug Products*.
20. Certain New Prescription Drug Products and/or new dosage forms until the date they are reviewed and assigned to a tier by our PDL Management Committee.
21. Growth hormone for children with familial short stature (short stature based upon heredity and not caused by a diagnosed medical condition).
22. Any medication that is used for the treatment of erectile dysfunction or sexual dysfunction.

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23. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, and prescription medical food products even when used for the treatment of Sickness or Injury, except for Eosinophilic Gastrointestinal Disorder Formula or for Medical Foods prescribed for the treatment of Inherited Metabolic Disorder in *Section 3: Defined Terms* of this *Rider*.
24. A Prescription Drug Product that contains (an) active ingredient(s) available in and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
25. A Prescription Drug Product that contains (an) active ingredient(s) which is (are) a modified version of and Therapeutically Equivalent to another covered Prescription Drug Product. Such determinations may be made up to six times during a calendar year, and we may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision.
26. Certain Prescription Drug Products that have not been prescribed by a Specialist Physician.
27. A Prescription Drug Product that contains marijuana, including medical marijuana.
28. Certain Prescription Drug Products that exceed the minimum number of drugs required to be covered under PPACA essential health benefit requirements in the applicable United States Pharmacopeia category and class or applicable state benchmark plan category and class.
29. Dental products, including but not limited to prescription fluoride topicals.

Section 3: Defined Terms

Ancillary Charge - a charge, in addition to the Copayment and/or Coinsurance, that you are required to pay when a covered Prescription Drug Product is dispensed at your or the provider's request, when a Chemically Equivalent Prescription Drug Product is available on a lower tier. For Prescription Drug Products from Network Pharmacies, the Ancillary Charge is calculated as the difference between the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price for Network Pharmacies for the Prescription Drug Product on the higher tier, and the Prescription Drug Charge or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier. For Prescription Drug Products from non-Network Pharmacies, the Ancillary Charge is calculated as the difference between the Predominant Reimbursement Rate or Maximum Allowable Cost (MAC) List price for non-Network Pharmacies for the Prescription Drug Product on the higher tier, and the Predominant Reimbursement Rate or Maximum Allowable Cost (MAC) List price of the Chemically Equivalent Prescription Drug Product available on the lower tier.

Brand-name - a Prescription Drug Product: (1) which is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that we identify as a Brand-name product, based on available data resources including, but not limited to, data sources such as medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "brand name" by the manufacturer, pharmacy, or your Physician may not be classified as Brand-name by us.

Chemically Equivalent - when Prescription Drug Products contain the same active ingredient.

Designated Pharmacy - a pharmacy that has entered into an agreement with us or with an organization contracting on our behalf, to provide specific Prescription Drug Products, including, but not limited to, Specialty Prescription Drug Products. The fact that a pharmacy is a Network Pharmacy does not mean that it is a Designated Pharmacy.

Eosinophilic Gastrointestinal Disorder Formula - amino acid-based formula used in the treatment of a Covered Person who has been diagnosed as having an eosinophilic gastrointestinal disorder, subject to the following conditions:

- The Covered Person must be under the continuous supervision of a Physician who is licensed under Title 32, Chapter 13 or 17 of the Arizona Revised Statutes or a registered nurse practitioner who is licensed under Title 32, Chapter 15 of the Arizona Revised Statutes.
- The formula must be prescribed or ordered by a Physician or a registered nurse practitioner.
- There must be a risk of mental or physical impairment to the Covered Person without the use of the formula.

Generic - a Prescription Drug Product: (1) that is Chemically Equivalent to a Brand-name drug; or (2) that we identify as a Generic product based on available data resources including, but not limited to, data sources such as medi-span or First DataBank, that classify drugs as either brand or generic based on a number of factors. You should know that all products identified as a "generic" by the manufacturer, pharmacy or your Physician may not be classified as a Generic by us.

Inherited Metabolic Disorder - a disease or disorder caused by an inherited abnormality of body chemistry, including a disease or disorder tested under the newborn screening program:

- Which involves amino acid, carbohydrate and fat metabolism.
- For which medically standard methods of diagnosis, treatment, and monitoring exist.
- Which requires specifically processed or treated Medical Foods that are generally available only under the supervision and direction of a Physician or a registered nurse practitioner with special training in the diagnosis and treatment of patients with genetic inborn errors of metabolism and that

must be consumed throughout life and without which the person may suffer serious mental or physical impairment.

Maximum Allowable Cost (MAC) List - a list of Generic Prescription Drug Products that will be covered at a price level that we establish. This list is subject to our periodic review and modification.

Medical Foods - modified nutritional substances in any form that are all of the following:

- Used in the treatment of Inherited Metabolic Disorders to compensate for the metabolic abnormality and to maintain adequate nutritional status.
- Formulated to be consumed or administered enterally under the supervision of a Physician or a registered nurse practitioner.
- Specifically processed or formulated to be deficient in one or more nutrients present in typical foodstuffs. This does not include a natural food or food product that is naturally low in protein.
- Intended for the medical and nutritional management of patients who have limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation.
- Essential to optimize growth, health, and metabolic homeostasis.

Network Pharmacy - a pharmacy that has:

- Entered into an agreement with us or an organization contracting on our behalf to provide Prescription Drug Products to Covered Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by us as a Network Pharmacy.

New Prescription Drug Product - a Prescription Drug Product or new dosage form of a previously approved Prescription Drug Product, for the period of time starting on the date the Prescription Drug Product or new dosage form is approved by the *U.S. Food and Drug Administration (FDA)* and ending on the earlier of the following dates:

- The date it is assigned to a tier by our PDL Management Committee.
- December 31st of the following calendar year.

Non-Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a non-preferred pharmacy within the Network.

Out-of-Pocket Drug Maximum - the maximum amount you are required to pay for covered Prescription Drug Products in a single year. Refer to the *Outpatient Prescription Drug Schedule of Benefits* for details about how the Out-of-Pocket Drug Maximum applies.

Predominant Reimbursement Rate - the amount we will pay to reimburse you for a Prescription Drug Product that is dispensed at a non-Network Pharmacy. The Predominant Reimbursement Rate for a particular Prescription Drug Product dispensed at a non-Network Pharmacy includes a dispensing fee and any applicable sales tax. We calculate the Predominant Reimbursement Rate using our Prescription Drug Charge that applies for that particular Prescription Drug Product at most Network Pharmacies.

Preferred Retail Network Pharmacy - a retail pharmacy that we identify as a preferred pharmacy within the Network.

Prescription Drug Charge - the rate we have agreed to pay our Network Pharmacies, including the applicable dispensing fee and any applicable sales tax, for a Prescription Drug Product dispensed at a Network Pharmacy.

Prescription Drug List - a list that categorizes into tiers medications, products or devices that have been approved by the *U.S. Food and Drug Administration (FDA)*. This list is subject to our periodic review and modification (generally quarterly, but no more than six times per calendar year). The Prescription Drug List is developed through an evidence-based evaluation when determining which Prescription Drug Products are covered or excluded under the Policy. Medications may be excluded from coverage when it works the same or similar as another prescription medication or an over-the-counter medication. You may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Prescription Drug List (PDL) Management Committee - the committee that we designate for, among other responsibilities, classifying Prescription Drug Products into specific tiers.

Prescription Drug Product - a medication, product or device that has been approved by the *U.S. Food and Drug Administration (FDA)* and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of Benefits under the Policy, this definition includes:

- Inhalers (with spacers).
- Insulin.
- The following diabetic supplies:
 - blood glucose monitors;
 - blood glucose monitors for the legally blind;
 - test strips for glucose monitors and visual reading and urine testing strips;
 - insulin preparations and glucagon;
 - insulin cartridges;
 - drawing up devices and monitors for the visually impaired;
 - injection aids;
 - insulin cartridges for the legally blind;
 - syringes and lancets, including automatic lancing devices;
 - prescribed oral agents for controlling blood sugar; and
 - any other device, medication, equipment or supply for which coverage is required under Medicare on or after January 1, 1999.

Prescription Order or Refill- the directive to dispense a Prescription Drug Product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

Preventive Care Medications – the medications that are obtained at a Network Pharmacy with a Prescription Order or Refill from a Physician and that are payable at 100% of the cost (without application of any Copayment, Coinsurance, Annual Deductible or Annual Drug Deductible) as required by applicable law under any of the following:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the *United States Preventive Services Task Force*.
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the *Health Resources and Services Administration*.

- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the *Health Resources and Services Administration*.

You may determine whether a drug is a Preventive Care Medication through the internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Specialty Prescription Drug Product - Prescription Drug Products that are generally high cost, self-administered biotechnology drugs used to treat patients with certain illnesses. You may access a complete list of Specialty Prescription Drug Products through the Internet at www.myuhc.com or by calling *Customer Care* at the telephone number on your ID card.

Therapeutically Equivalent - when Prescription Drug Products have essentially the same efficacy and adverse effect profile.

Usual and Customary Charge - the usual fee that a pharmacy charges individuals for a Prescription Drug Product without reference to reimbursement to the pharmacy by third parties. The Usual and Customary Charge includes a dispensing fee and any applicable sales tax.

Section 4: Your Right to Request an Exclusion Exception

When a Prescription Drug Product is excluded from coverage, you or your representative may request an exception to gain access to the excluded Prescription Drug Product. To make a request, contact us in writing or call the toll-free number on your ID card. We will notify you of our determination within 72 hours.

Urgent Requests

If your request requires immediate action and a delay could significantly increase the risk to your health, or the ability to regain maximum function, call us as soon as possible. We will provide a written or electronic determination within 24 hours.

External Review

If you are not satisfied with our determination of your exclusion exception request, you may be entitled to request an external review. You or your representative may request an external review by sending a written request to us to the address set out in the determination letter or by calling the toll-free number on your ID card. The *Independent Review Organization (IRO)* will notify you of our determination within 72 hours.

Expedited External Review

If you are not satisfied with our determination of your exclusion exception request and it involves an urgent situation, you or your representative may request an expedited external review by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. The *IRO* will notify you of our determination within 24 hours.

Pediatric Dental Services Rider

All Savers Insurance Company

This Rider to the Policy provides Benefits for Covered Dental Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Marketplace.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Policy in *Section 8: Defined Terms* or in this Rider in *Section 5: Defined Terms for Pediatric Dental Services*.

When we use the words "we," "us," and "our" in this document, we are referring to All Savers Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the Policy in *Section 8: Defined Terms*.

Patrick F. Carr



Section 1: Accessing Pediatric Dental Services

Network and Non-Network Benefits

Network Benefits - these Benefits apply when you choose to obtain Covered Dental Services from a Network Dental Provider. You generally are required to pay less to the provider than you would pay for services from a non-Network provider. Network Benefits are determined based on the contracted fee for each Covered Dental Service. In no event, will you be required to pay a Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee.

In order for Covered Dental Services to be paid as Network Benefits, you must obtain all Covered Dental Services directly from or through a Network Dental Provider.

You must always verify the participation status of a provider prior to seeking services. From time to time, the participation status of a provider may change. You can verify the participation status by calling us and/or the provider. If necessary, we can provide assistance in referring you to Network Dental Provider.

We will make available to you a *Directory of Network Dental Providers*. You can also call *Customer Service* to determine which providers participate in the Network. The telephone number for *Customer Service* is on your ID card.

Non-Network Benefits - these Benefits apply when you decide to obtain Covered Dental Services from non-Network Dental Providers. You generally are required to pay more to the provider than for Network Benefits. Non-Network Benefits are determined based on our contracted fee(s) for Covered Dental Services with a Network Dental Provider in the same geographic area for each Covered Dental Service. The actual charge made by a non-Network Dental Provider for a Covered Dental Service may exceed the contracted fee(s). As a result, you may be required to pay a non-Network Dental Provider an amount for a Covered Dental Service in excess of the contracted fee(s). In addition, when you obtain Covered Dental Services from non-Network Dental Providers, you must file a claim with us to be reimbursed for Eligible Dental Expenses.

Covered Dental Services

You are eligible for Benefits for Covered Dental Services listed in this Rider if such Dental Services are Necessary and are provided by or under the direction of a Network Dental Provider.

Benefits are available only for Necessary Dental Services. The fact that a Dental Provider has performed or prescribed a procedure or treatment, or the fact that it may be the only available treatment, for a dental disease does not mean that the procedure or treatment is a Covered Dental Service under this Rider.

Pre-Treatment Estimate

If the charge for a Dental Service is expected to exceed \$500 or if a dental exam reveals the need for fixed bridgework, you may notify us of such treatment before treatment begins and receive a pre-treatment estimate. If you desire a pre-treatment estimate, you or your Dental Provider should send a notice to us, via claim form, within 20 calendar days of the exam. If requested, the Dental Provider must provide us with dental x-rays, study models or other information necessary to evaluate the treatment plan for purposes of benefit determination.

We will determine if the proposed treatment is a Covered Dental Service and will estimate the amount of payment. The estimate of Benefits payable will be sent to the Dental Provider and will be subject to all terms, conditions and provisions of the Policy. Clinical situations that can be effectively treated by a less costly, clinically acceptable alternative procedure will be assigned a benefit based on the less costly procedure.

A pre-treatment estimate of Benefits is not an agreement to pay for expenses. This procedure lets you know in advance approximately what portion of the expenses will be considered for payment.

Pre-Authorization

Pre-authorization is required for orthodontic services. Speak to your Dental Provider about obtaining a pre-authorization before Dental Services are rendered. If you do not obtain a pre-authorization, we have a right to deny your claim for failure to comply with this requirement.

Section 2: Benefits for Pediatric Dental Services

Benefits are provided for the Dental Services stated in this Section when such services are:

- A. Necessary.
- B. Provided by or under the direction of a Dental Provider.
- C. Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a Benefit based on the least costly procedure.
- D. Not excluded as described in *Section 3: Pediatric Dental Services exclusions* of this Rider.

Network Benefits:

Benefits for Eligible Dental Expenses are determined as a percentage of the negotiated contract fee between us and the provider rather than a percentage of the provider's billed charge. Our negotiated rate with the provider is ordinarily lower than the provider's billed charge.

A Network provider cannot charge you or us for any service or supply that is not Necessary as determined by us. If you agree to receive a service or supply that is not Necessary the Network provider may charge you. However, these charges will not be considered Covered Dental Services and Benefits will not be payable.

Non-Network Benefits:

Benefits for Eligible Dental Expenses from non-Network providers are determined as a percentage of our contracted fee(s) for Covered Dental Services with a Network Dental Provider in the same geographic area. You must pay the amount by which the non-Network provider's billed charge exceeds the Eligible Dental Expense.

Annual Deductible

Benefits for pediatric Dental Services provided under this Rider are subject to the Annual Deductible stated in the *Schedule of Benefits*.

Out-of-Pocket Maximum - Any amount you pay in Copayments and Annual Deductible for pediatric Dental Services under this Rider applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Benefit Description

Benefit Description and Limitations	Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.	Non-Network Benefits Benefits are shown as a percentage of Eligible Dental Expenses.
DIAGNOSTIC SERVICES - (Not subject to payment of the Annual Deductible.)		
D0120 Periodic Oral Evaluation	100%	50%
D0140 Limited Oral Evaluation – Problem Focused		

D0150 Comprehensive Oral Evaluation D0180 Comprehensive Periodontal Evaluation Limited to 1 time per 6 months D0160 Detailed and extensive Oral Evaluation – Problem focused		
D0210 Intraoral - Complete Series (Including Bitewings) Limited to 1 every 60 months	100%	50%
D0220 Intraoral – Periapical first film D0230 Intraoral – Periapical – each additional film D0240 Intraoral – Occlusal Film	100%	50%
D0270 Bitewings – single film D0272 Bitewings – two films D0274 Bitewings – four films D0277 Vertical Bitewings Limited to 1 set every 6 months	100%	50%
D0330 Panoramic Radiograph Image Limited to 1 film per 60 months	100%	50%
D0340 Cephalometric x-ray D0350 Oral/Facial Photographic Images D0470 Diagnostic Casts	100%	50%
PREVENTIVE SERVICES -(Not subject to payment of the Annual Deductible.)		
D1110 Prophylaxis - Adult D1120 Prophylaxis – Child Limited to 1 per 6 months	100%	50%
D1206 and D1208 Fluoride Limited to 2 per 12 months	100%	50%
D1351 Sealant – per tooth – unrestored permanent molar D1352 Preventative resin restorations in moderate to high caries risk patient – permanent tooth Limited to 1 per 36 months	100%	50%
D1510 Space Maintainer – Fixed - Unilateral D1515 Space Maintainer – Fixed - Bilateral D1520 Space Maintainer – Removable - Unilateral D1525 Space Maintainer – Removable - Bilateral D1550 Re-cementation of Space Maintainer	100%	50%
MINOR RESTORATIVE SERVICES - (Subject to payment of the Annual Deductible.)		
D2140 Amalgams – One surface, primary or permanent D2150 Amalgams – Two surfaces, primary or permanent D2160 Amalgams – Three surfaces, primary or permanent D2161 Amalgams – Four or more surfaces, primary or permanent	100%	50%
D2330 Resin-based composite – One surface, anterior D2331 Resin-based composite – Two surfaces, anterior	100%	50%

D2332 Resin-based composite – three surfaces, anterior D2335 Resin-based composite – Four or more surfaces or involving incised angle (anterior)		
CROWNS/INLAYS/ONLAYS - (Subject to payment of the Annual Deductible.)		
Replacement of complete dentures, fixed and removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 60 months from initial or supplemental placement.		
D2542 Onlay – metallic – two surfaces D2543 Onlay – metallic – three surfaces D2544 Onlay – metallic – four surfaces D2740 Crown – porcelain/ceramic substrate D2750 Crown – porcelain fused to high noble metal D2751 Crown – porcelain fused to predominately base metal D2752 Crown – porcelain fused to noble metal D2780 Crown – $\frac{3}{4}$ cast high noble metal D2781 Crown – $\frac{3}{4}$ cast predominately base metal D2783 Crown – $\frac{3}{4}$ porcelain/ceramic D2790 Crown – full cast high noble metal D2791 Crown – full cast predominately base metal D2792 Crown – full cast noble metal D2794 Crown - titanium D2930 Prefabricated stainless steel crown – primary tooth D2931 Prefabricated stainless steel crown – permanent tooth Limited to 1 time per 60 months D2510 Inlay – metallic – one surface D2520 Inlay – metallic – two surfaces D2530 Inlay – metallic – three surfaces D2910 Re-cement inlay D2920 Re-cement crown	100%	50%
D2940 Protective Restoration	100%	50%
D2950 Core Buildup, including any pins Limited to 1 time per tooth per 60 months	100%	50%
D2951 Pin Retention - Per Tooth, in addition to Restoration	100%	50%
D2954 Prefabricated Post and Core in addition to Crown Limited to 1 time per tooth per 60 months	100%	50%
D2980 Crown Repair Necessitated by Restorative Material Failure	100%	50%
ENDODONTICS - (Subject to payment of the Annual Deductible.)		

D3220 Therapeutic Pulpotomy (excluding final restoration)	100%	50%
D3222 Partial Pulpotomy for Apexogenesis - Permanent Tooth with Incomplete Root Development	100%	50%
D3230 Pulpal Therapy (resorbable filling) – Anterior, Primary Tooth (excluding final restoration) D3240 Pulpal Therapy (resorbable filling) – Posterior, Primary Tooth (excluding final restoration)	100%	50%
D3310 Anterior root canal (excluding final restoration) D3320 Bicuspid root canal (excluding final restoration) D3330 Molar root canal (excluding final restoration) D3346 Retreatment of previous root canal therapy - anterior D3347 Retreatment of previous root canal therapy - bicuspid D3348 Retreatment of previous root canal therapy - molar	100%	50%
D3351 Apexification/recalcification – initial visit D3352 Apexification/recalcification – interim medication replacement D3353 Apexification/recalcification – final visit	100%	50%
D3354 Pulpal Regeneration	100%	50%
D3410 Apicoectomy/periradicular surgery - anterior D3421 Apicoectomy/periradicular surgery - bicuspid D3425 Apicoectomy/periradicular surgery - molar D3426 Apicoectomy/Periradicular Surgery each additional root	100%	50%
D3450 Root Amputation - Per Root	100%	50%
D3920 Hemisection (including any root removal), not including Root Canal Therapy	100%	50%
PERIODONTICS - (Subject to payment of the Annual Deductible.)		
D4210 Gingivectomy or gingivoplasty – four or more teeth D4211 Gingivectomy or gingivoplasty – one to three teeth Limited to 1 every 36 months	100%	50%
D4240 Gingival Flap Procedure, four or more teeth Limited to 1 every 36 months	100%	50%
D4249 Clinical Crown Lengthening - Hard Tissue	100%	50%

D4260 Osseous Surgery Limited to 1 every 36 months	100%	50%
D4270 Pedicle Soft Tissue Graft Procedure D4271 Free soft tissue graft procedure	100%	50%
D4273 Subepithelial Connective Tissue Graft Procedures, Per Tooth	100%	50%
D4341 Periodontal scaling and root planning – four or more teeth per quadrant D4342 Periodontal scaling and root planning – one to three teeth, per quadrant Limited to 1 time per quadrant per 24 months	100%	50%
D4355 Full Mouth Debridement to Enable Comprehensive Evaluation and Diagnosis Limited to 1 per lifetime	100%	50%
D4910 Periodontal Maintenance Limited to 4 time per 12 months in combination with prophylaxis	100%	50%
REMOVABLE DENTURES - (Subject to payment of the Annual Deductible.)		
Replacement of complete dentures, fixed and removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 60 months from initial or supplemental placement.		
D5110 Complete denture – maxillary D5120 Complete denture - mandibular D5130 Immediate denture - maxillary D5140 Immediate denture - mandibular D5211 Mandibular partial denture – resin base D5212 Maxillary partial denture – resin base D5213 Maxillary partial denture – cast metal framework with resin denture base D5214 Mandibular partial denture – cast metal framework with resin denture base D5281 Removable unilateral partial denture – one piece cast metal Limited to 1 every 60 months	100%	50%
D5410 Adjust complete denture - maxillary D5411 Adjust complete denture - mandibular D5421 Adjust partial denture - maxillary D5422 Adjust partial denture - mandibular D5510 Repair broken complete denture base D5520 Replace missing or broken teeth – complete denture D5610 Repair resin denture base D5620 Repair cast framework D5630 Repair or replace broken clasp D5640 Replace broken teeth - per tooth D5650 Add tooth to existing partial denture D5660 Add clasp to existing partial denture	100%	50%

D5710 Rebase complete maxillary denture D5720 Rebase maxillary partial denture D5721 Rebase mandibular partial denture D5730 Reline complete maxillary denture D5731 Reline complete mandibular denture D5740 Reline maxillary partial denture D5741 Reline mandibular partial denture D5750 Reline complete maxillary denture (laboratory) D5751 Reline complete mandibular denture (laboratory) D5760 Reline maxillary partial denture (laboratory) D5761 Reline mandibular partial denture (laboratory) Limited to rebasing performed more than 6 months after the initial insertion. Limited to 1 time per 36 months	100%	50%
D5850 Tissue conditioning (maxillary) D5851 Tissue conditioning (mandibular)	100%	50%
BRIDGES (fixed partial dentures) - (Subject to payment of the Annual Deductible.)		
Replacement of complete dentures, fixed and removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per 60 months from initial or supplemental placement.		
D6210 Pontic – cast high noble metal D6211 Pontic – cast predominately base metal D6212 Pontic – cast noble metal D6214 Pontic – titanium D6240 Pontic – porcelain fused to high noble metal D6241 Pontic – porcelain fused to predominately base metal D6242 Pontic – porcelain fused to noble metal D6245 Pontic – porcelain/ceramic	100%	50%
D6545 Retainer – cast metal for resin bonded fixed prosthesis D6548 Retainer – porcelain/ceramic for resin bonded fixed prosthesis	100%	50%
D6519 Inlay/onlay – porcelain/ceramic D6520 Inlay – metallic – two surfaces D6530 Inlay – metallic – three or more surfaces D6543 Onlay – metallic – three surfaces D6544 Onlay – metallic – four or more surfaces	100%	50%
D6740 Crown – porcelain/ceramic D6750 Crown – porcelain fused to high noble metal D6751 Crown – porcelain fused to predominately base metal D6752 Crown – porcelain fused to noble metal D6780 Crown – $\frac{3}{4}$ cast high noble metal D6781 Crown – $\frac{3}{4}$ cast predominately base metal D6782 Crown – $\frac{3}{4}$ cast noble metal D6783 Crown – $\frac{3}{4}$ porcelain/ceramic D6790 Crown – full cast high noble metal D6791 Crown – full cast predominately base metal D6792 Crown – full cast noble metal	100%	50%

Limited to 1 time per 60 months		
D6930 Re-cement or Re-bond Fixed Partial Denture	100%	50%
D6973 Core build up for retainer, including any pins D6980 Fixed Partial Denture Repair Necessitated by Restorative Material Failure	100%	50%
ORAL SURGERY - (Subject to payment of the Annual Deductible.)		
D7140 Extraction, erupted tooth or exposed root	100%	50%
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth D7220 Removal of impacted tooth – soft tissue D7230 Removal of impacted tooth – partially bony D7240 Removal of impacted tooth – completely bony D7241 Removal of impacted tooth – complete bony with unusual surgical complications D7250 Surgical removal of residual tooth roots D7251 Coronectomy – intentional partial tooth removal	100%	50%
D7270 Tooth Reimplantation and/or Stabilization of Accidentally Evulsed or Displaced Tooth	100%	100%
D7280 Surgical Access of an Unerrupted Tooth	100%	50%
D7310 Alveoloplasty in conjunction with extractions – per quadrant D7311 Alveoloplasty in conjunction with extractions – one to three teeth or tooth space – per quadrant D7320 Alveoloplasty not in conjunction with extractions – per quadrant D7321 Alveoloplasty not in conjunction with extractions – one to three teeth or tooth space – per quadrant	100%	50%
D7471 Removal of Lateral Exostosis (Maxilla or Mandible)	100%	50%
D7510 Incision and Drainage of Abscess D7910 Suture of recent small wounds up to 5 cm D7971 Excision of pericoronal gingiva	100%	50%
ADJUNCTIVE SERVICES - (Subject to payment of the Annual Deductible.)		
D9110 Palliative (Emergency) Treatment of Dental Pain - Minor Procedure Covered as a separate benefit only if no other services, other than the exam and radiographs, were done on the same tooth during the visit.	100%	50%
D9220 Deep sedation/general anesthesia first 30 minutes D9221 Dental sedation/general anesthesia each additional 15 minutes D9241 Intravenous conscious sedation/analgesia – first 30 minutes D9242 Intravenous conscious sedation/analgesia – each additional 15 minutes D9610 Therapeutic drug injection, by report Covered only when clinically necessary	100%	50%

D9310 Consultation (diagnostic service provided by Dentist or Physician other than practitioner providing treatment) D9930 Treatment of complications (post-surgical) - unusual circumstances, by report Covered only when clinically necessary	100%	50%
D9940 Occlusal Guard Limited to 1 guard every 12 months.	100%	50%
IMPLANT PROCEDURES - (Subject to payment of the Annual Deductible.)		
Replacement of implants, implant crowns, implant prostheses, and implant supporting structures (such as connectors) previously submitted for payment under the plan is limited to 1 time per 60 months from initial or supplemental placement.		
D6010 Endosteal Implant D6012 Surgical Placement of Interim Implant Body D6040 Eposteal Implant D6050 Transosteal Implant, including hardware D6053 Implant supported complete denture D6054 Implant supported partial denture D6055 Connecting Bar implant or abutment supported D6056 Prefabricated Abutment D6058 Abutment supported porcelain ceramic crown D6059 Abutment supported porcelain fused to high noble metal D6060 Abutment supported poscelain fused to predominately base metal crown D6061 Abutment supported porcelain fused to noble metal crown D6062 Abutment supported cast high noble metal crown D6063 Abutment supported case predominately base metal crown D6064 Abutment supported porcelain/ceramic crown D6065 Implant supported porcelain/ceramic crown D6066 Implant supported porcelain fused to high metal crown D6067 Implant supported metal crown D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture D6072 Abutment supported retainer for cast high noble metal fixed partial denture D6073 Abutment supported retainer for predominately base metal fixed partial denture D6074 Abutment supported retainer for cast metal fixed partial denture D6075 Implant supported retainer for ceramic fixed partial denture D6076 Implant supported retainer for porcelain fused to	100%	50%

high noble metal fixed partial denture D6077 Implant supported retainer for cast metal fixed partial denture D6078 Implant/abutment supported fixed partial denture for completely edentulous arch D6079 Implant/abutment supported fixed partial denture for partially edentulous arch D6080 Implant Maintenance Procedure D6090 Repair Implant Prosthesis D6091 Replacement of Semi-Precision or Precision Attachment D6095 Repair Implant Abutment D6100 Implant Removal D6190 Implant Index Limited to 1 time per 60 months		
MEDICALLY NECESSARY ORTHODONTICS - (Subject to payment of the Annual Deductible.)		
<p>Benefits for comprehensive orthodontic treatment are approved by us, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crozon's syndrome, Treacher-Collins syndrome, Pierre-Robin syndrome, hemi-facial atrophy, hemi-facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by our dental consultants. Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.</p> <p>All orthodontic treatment must be prior authorized.</p> <p>Benefits will be paid in equal monthly installments over the course of the entire orthodontic treatment plan, starting on the date that the orthodontic bands or appliances are first placed, or on the date a one-step orthodontic procedure is performed.</p> <p>Services or supplies furnished by a Dental Provider in order to diagnose or correct misalignment of the teeth or the bite. Benefits are available only when the service or supply is determined to be medically necessary.</p>		
D8010 Limited orthodontic treatment of the primary dentition D8020 Limited orthodontic treatment of the transitional dentition D8030 Limited orthodontic treatment of the adolescent dentition D8050 Interceptive orthodontic treatment of the primary dentition D8060 Interceptive orthodontic treatment of the transitional dentition D8070 Comprehensive orthodontic treatment of the transitional dentition D8080 Comprehensive orthodontic treatment of the adolescent dentition D8210 Removable appliance therapy D8220 Fixed appliance therapy D8660 Pre-orthodontic treatment visit D8670 Periodic orthodontic treatment visit D8680 Orthodontic retention	100%	50%

Section 3: Pediatric Dental Exclusions

Except as may be specifically provided in this Rider under *Section 2: Benefits for Covered Dental Services*, Benefits are not provided under this Rider for the following:

1. Any Dental Service or Procedure not listed as a Covered Dental Service in this Rider in *Section 2: Benefits for Covered Dental Services*.
2. Dental Services that are not Necessary.
3. Hospitalization or other facility charges. This exclusion does not apply to Benefits provided under *Dental Services - Hospital or Alternative Facility/Anesthesia* in *Section 1: Covered Health Services of the Policy*.
4. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
5. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, Injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body. This exclusion does not apply to Benefits provided under *Reconstructive Procedures* in *Section 1: Covered Health Services of the Policy*.
6. Any Dental Procedure not directly associated with dental disease.
7. Any Dental Procedure not performed in a dental setting.
8. Procedures that are considered to be Experimental or Investigational or Unproven Services. This includes pharmacological regimens not accepted by the *American Dental Association (ADA) Council on Dental Therapeutics*. The fact that an Experimental, or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue. This exclusion does not apply to Benefits provided under *Reconstructive Procedures* in *Section 1: Covered Health Services of the Policy*.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision. This exclusion does not apply to Benefits provided under *Reconstructive Procedures* in *Section 1: Covered Health Services of the Policy*.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns and implants, implant crowns and prosthesis if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dental Provider. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). Orthognathic surgery, jaw alignment, and treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled for coverage provided through this Rider to the Policy.
16. Dental Services otherwise covered under the Policy, but rendered after the date individual coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual coverage under the Policy terminates.

17. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child.
18. Foreign Services are not covered unless required as an Emergency.
19. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction. This exclusion does not apply to Benefits provided under *Reconstructive Procedures* in *Section 1: Covered Health Services* of the *Policy*.
20. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
21. Billing for incision and drainage if the involved abscessed tooth is removed on the same date of service.
22. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic coverage does not include the installation of a space maintainer, any treatment related to treatment of the temporomandibular joint, any surgical procedure to correct a malocclusion, replacement of lost or broken retainers and/or habit appliances, and any fixed or removable interceptive orthodontic appliances previously submitted for payment under the plan. This exclusion does not apply to Benefits provided under *Reconstructive Procedures* in *Section 1: Covered Health Services* of the *Policy*.

Section 4: Claims for Pediatric Dental Services

When obtaining Dental Services from a non-Network provider, you will be required to pay all billed charges directly to your Dental Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* apply to Covered Dental Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Dental Services

You are responsible for sending a request for reimbursement to our office, on a form provided by or satisfactory to us.

Claim Forms. It is not necessary to include a claim form with the proof of loss. However, the proof must include all of the following information:

- Covered Person's name and address.
- Covered Person's identification number.
- The name and address of the provider of the service(s).
- A diagnosis from the Dental Provider including a complete dental chart showing extractions, fillings or other dental services rendered before the charge was incurred for the claim.
- Radiographs, lab or hospital reports.
- Casts, molds or study models.
- Itemized bill which includes the *CPT* or *ADA* codes or description of each charge.
- The date the dental disease began.
- A statement indicating that you are or you are not enrolled for coverage under any other health or dental insurance plan or program. If you are enrolled for other coverage you must include the name of the other carrier(s).

If you would like to use a claim form, call us at the telephone number stated on your ID Card and a claim form will be sent to you. If you do not receive the claim form within 15 calendar days of your request, send in the proof of loss with the information stated above.

Section 5: Defined Terms for Pediatric Dental Services

The following definitions are in addition to those listed in *Section 8: Defined Terms* of the Policy:

Covered Dental Service – a Dental Service or Dental Procedure for which Benefits are provided under this Rider.

Dental Provider - any dentist or dental practitioner who is duly licensed and qualified under the law of jurisdiction in which treatment is received to render Dental Services, perform dental surgery or administer anesthetics for dental surgery.

Dental Service or Dental Procedures - dental care or treatment provided by a Dental Provider to a Covered Person while the Policy is in effect, provided such care or treatment is recognized by us as a generally accepted form of care or treatment according to prevailing standards of dental practice.

Eligible Dental Expenses - Eligible Dental Expenses for Covered Dental Services, incurred while the Policy is in effect, are determined as stated below:

- For Network Benefits, when Covered Dental Services are received from Network Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with that provider.
- For Non-Network Benefits, when Covered Dental Services are received from Non-Network Dental Providers, Eligible Dental Expenses are our contracted fee(s) for Covered Dental Services with a Network Dental Provider in the same geographic area.
- **Necessary** - Dental Services and supplies under this Rider which are determined by us through case-by-case assessments of care based on accepted dental practices to be appropriate and are all of the following:
 - Necessary to meet the basic dental needs of the Covered Person.
 - Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the Dental Service.
 - Consistent in type, frequency and duration of treatment with scientifically based guidelines of national clinical, research, or health care coverage organizations or governmental agencies that are accepted by us.
 - Consistent with the diagnosis of the condition.
 - Required for reasons other than the convenience of the Covered Person or his or her Dental Provider.
 - Demonstrated through prevailing peer-reviewed dental literature to be either:
 - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
 - Safe with promising efficacy
 - ♦ For treating a life threatening dental disease or condition.
 - ♦ Provided in a clinically controlled research setting.
 - ♦ Using a specific research protocol that meets standards equivalent to those defined by the *National Institutes of Health*.

(For the purpose of this definition, the term life threatening is used to describe dental diseases or sicknesses or conditions, which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Dental Provider has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular dental disease does not mean that it is a Necessary Covered Dental Service as defined in this Rider. The definition of Necessary used in this Rider relates only to Benefits under this Rider and differs from the way in which a Dental Provider engaged in the practice of dentistry may define necessary.

Pediatric Vision Care Services Rider

All Savers Insurance Company

This Rider to the Policy provides Benefits for Vision Care Services, as described below, for Covered Persons under the age of 19. Benefits under this Rider terminate when the Covered Person reaches the age of 19, as determined by the eligibility rules of the Marketplace.

Because this Rider is part of a legal document, we want to give you information about the document that will help you understand it. Certain capitalized words have special meanings. We have defined these words in either the Policy in *Section 8: Defined Terms* or in this Rider in *Section 4: Defined Terms for Pediatric Vision Care Services*.

When we use the words "we," "us," and "our" in this document, we are referring to All Savers Insurance Company. When we use the words "you" and "your" we are referring to people who are Covered Persons, as the term is defined in the Policy in *Section 8: Defined Terms*.

Patrick F. Carr



Section 1: Benefits for Pediatric Vision Care Services

Benefits are available for pediatric Vision Care Services from a Spectera Eyecare Networks or non-Network Vision Care Provider. To find a Spectera Eyecare Networks Vision Care Provider, you may call the provider locator service at 1-800-839-3242. You may also access a listing of Spectera Eyecare Networks Vision Care Providers on the Internet at www.myuhcvision.com.

When you obtain Vision Care Services from a non-Network Vision Care Provider, you will be required to pay all billed charges at the time of service. You may then seek reimbursement from us as described in the Policy in *Section 5: How to File a Claim* and in this Rider under *Section 3: Claims for Vision Care Services*. Reimbursement will be limited to the amounts stated below.

Network Benefits:

Benefits for Vision Care Services are determined based on the negotiated contract fee between us and the Vision Care Provider. Our negotiated rate with the Vision Care Provider is ordinarily lower than the Vision Care Provider's billed charge.

Non-Network Benefits:

Benefits for Vision Care Services from non-Network providers are determined as a percentage of the provider's billed charge.

Out-of-Pocket Maximum - any amount you pay in Coinsurance for Vision Care Services under this Rider applies to the Out-of-Pocket Maximum stated in the *Schedule of Benefits*.

Annual Deductible

Benefits for pediatric Vision Care Services provided under this Rider are subject to any Annual Deductible stated in the medical *Schedule of Benefits*.

Benefit Description

Benefits

When Benefit limits apply, the limit stated refers to any combination of Network Benefits and Non-Network Benefits unless otherwise specifically stated.

Benefit limits are calculated on a calendar year basis unless otherwise specifically stated.

Frequency of Service Limits

Benefits are provided for the Vision Care Services described below, subject to *Frequency of Service* limits and Coinsurance stated under each Vision Care Service in the *Schedule of Benefits* below.

Routine Vision Examination

A routine vision examination of the condition of the eyes and principal vision functions according to the standards of care in the jurisdiction in which you reside, including:

- A case history that includes chief complaint and/or reason for examination, patient medical/eye history, and current medications.
- Recording of monocular and binocular visual acuity, far and near, with and without present correction (for example, 20/20 and 20/40).
- Cover test at 20 feet and 16 inches (checks eye alignment).
- Ocular motility including versions (how well eyes track) near point convergence (how well eyes move together for near vision tasks, such as reading), and depth perception.
- Pupil responses (neurological integrity).
- External exam.
- Retinoscopy (when applicable) – objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.
- Phorometry/Binocular testing – far and near: how well eyes work as a team.
- Tests of accommodation and/or near point refraction: how well you see at near point (for example, reading).
- Tonometry, when indicated: test pressure in eye (glaucoma check).
- Ophthalmoscopic examination of the internal eye.
- Confrontation visual fields.
- Biomicroscopy.
- Color vision testing.
- Diagnosis/prognosis.
- Specific recommendations.

Post examination procedures will be performed only when materials are required.

Or, in lieu of a complete exam, Retinoscopy (when applicable) - objective refraction to determine lens power of corrective lenses and subjective refraction to determine lens power of corrective lenses.

Eyeglass Lenses

Lenses that are mounted in eyeglass frames and worn on the face to correct visual acuity limitations. Lenses include a choice of glass, plastic or polycarbonate.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Lens Extras

Eyeglass Lenses. The following Lens Extras are covered in full:

- Standard scratch-resistant coating.
- Polycarbonate lenses.

Eyeglass Frames

A structure that contains eyeglass lenses, holding the lenses in front of the eyes and supported by the bridge of the nose.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Contact Lenses

Lenses worn on the surface of the eye to correct visual acuity limitations.

Benefits include the fitting/evaluation fees and contacts.

You are eligible to select only one of either eyeglasses (*Eyeglass Lenses* and/or *Eyeglass Frames*) or *Contact Lenses*. If you select more than one of these Vision Care Services, we will pay Benefits for only one Vision Care Service.

Necessary Contact Lenses

Benefits are available when a Vision Care Provider has determined a need for and has prescribed the contact lens. Such determination will be made by the Vision Care Provider and not by us.

Contact lenses are necessary if you have any of the following:

- Keratoconus.
- Anisometropia.
- Irregular corneal/astigmatism.
- Aphakia.
- Facial deformity.
- Corneal deformity.

Low Vision

Benefits are available to Covered Persons who have severe visual problems that cannot be corrected with regular lenses and only when a Vision Care Provider has determined a need for and has prescribed the service. Such determination will be made by the Vision Care Provider and not by us.

Benefits include:

- Low vision testing: Complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.
- Low vision therapy: Subsequent low vision therapy if prescribed.

Schedule of Benefits

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
<i>Routine Vision Examination or Refraction only in lieu of a complete exam.</i>	Once every calendar year.	100%	50% of the billed charge.
<i>Eyeglass Lenses</i>	Once every calendar year.		

• <i>Single Vision</i>		100%	50% of the billed charge.
• <i>Bifocal</i>		100%	50% of the billed charge.
• <i>Trifocal</i>		100%	50% of the billed charge.
• <i>Lenticular</i>		100%	50% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
<i>Eyeglass Frames</i>	Once every calendar year.		
• <i>Eyeglass frames</i>		100%	50% of the billed charge.

Vision Care Service	Frequency of Service	Network Benefit	Non-Network Benefit
<i>Contact Lenses Fitting & Evaluation</i>	Limited to a 12 month supply.	100%	50% of the billed charge.
• <i>Covered Contact Lens Selection</i>	Limited to a 12 month supply.	100%	50% of the billed charge.
• <i>Necessary Contact Lenses</i>	Limited to a 12 month supply.	100%	50% of the billed charge.
Low Vision Services Note that Benefits for these services will be paid as reimbursements. When obtaining these Vision Services, you will be required to pay all billed charges at the time of service. You may then obtain reimbursement from us. Reimbursement will be limited to the amounts stated.	Once every 24 months		
• Low vision testing		100% of billed charges	75% of billed charges
• Low vision therapy		75% of billed charges	75% of billed charges

Section 2: Pediatric Vision Exclusions

Except as may be specifically provided in this Rider under *Section 1: Benefits for Pediatric Vision Care Services*, Benefits are not provided under this Rider for the following:

1. Medical or surgical treatment for eye disease which requires the services of a Physician and for which Benefits are available as stated in the Policy.
2. Non-prescription items (e.g. Plano lenses).
3. Replacement or repair of lenses and/or frames that have been lost or broken.
4. Optional Lens Extras not listed in *Section 1: Benefits for Vision Care Services*.
5. Missed appointment charges.
6. Applicable sales tax charged on Vision Care Services.

Section 3: Claims for Pediatric Vision Care Services

When obtaining Vision Care Services from a non-Network Vision Care Provider, you will be required to pay all billed charges directly to your Vision Care Provider. You may then seek reimbursement from us. Information about claim timelines and responsibilities in the Policy in *Section 5: How to File a Claim* applies to Vision Care Services provided under this Rider, except that when you submit your claim, you must provide us with all of the information identified below.

Reimbursement for Vision Care Services

To file a claim for reimbursement for Vision Care Services rendered by a non-Spectera Eyecare Networks Vision Care Provider, or for Vision Care Services covered as reimbursements (whether or not rendered by a Spectera Eyecare Networks Vision Care Provider or a non-Network Vision Care Provider), you must provide all of the following information on a claim form acceptable to us:

- Your itemized receipts.
- Covered Person's name.
- Covered Person's identification number from the ID card.
- Covered Person's date of birth.

Submit the above information to us:

By mail:

Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

By facsimile (fax):

248-733-6060

Section 4: Defined Terms for Pediatric Vision Care Services

The following definitions are in addition to those listed in *Section 8: Defined Terms* of the Policy:

Covered Contact Lens Selection - a selection of available contact lenses that may be obtained from a Spectera Eyecare Networks Vision Care Provider on a covered-in-full basis, subject to payment of any applicable Coinsurance.

Spectera Eyecare Networks - any optometrist, ophthalmologist, optician or other person designated by us who provides Vision Care Services for which Benefits are available under the Policy.

Vision Care Provider - any optometrist, ophthalmologist, optician or other person who may lawfully provide Vision Care Services.

Vision Care Service - any service or item listed in this Rider in *Section 1: Benefits for Pediatric Vision Care Services*.